City of Appleton

100 North Appleton Street
Appleton, WI 54911-4799
www.appleton.org

Meeting Agenda - Final

Library Board

Tuesday, January 16, 2024 | **4:30 PM** | **Council Chambers, 6th Floor**

1. Call meeting to order

2. Pledge of Allegiance

3. Roll call of membership

4. Approval of minutes from previous meeting

24-0040 December 19, 2023 Meeting Minutes

Attachments: 12-19-2023 Library Board Meeting Minutes.pdf

5. Public Participation & Communications

Establish Order of the Day

6. Action Items

24-0041 Bill Register - December 2023 (Partial)

Attachments: December 2023 Bill Register.pdf
APL Financial Cash Flow-December-2023.pdf
Friends Project Summary Report Q2.pdf

24-0042 January 2024 Budget Amendment

Attachments: Dec23 Budget Amendment.pdf

7. Information Items

A. Administrative Report

24-0043 Building Project Update

Attachments: 12.2023 - Appleton Public Library Month-End Report.pdf

24-0044 APL Hiring Process Update

24-0045 Library Legislative Day - Tuesday, February 6, 2024

Attachments: 2024 WLA LLD.pdf

24-0046 Library Board Meeting Tuesday, February 27, 2024 - Time Change Reminder 5:30pm

23-1519 APL Website Redesign

Attachments: Website Redesign Process Board of Trustees Meeting.pdf

B. Presidents Report

23-1516 Trustee Development - Public Health Overview

Attachments: FPHS-Factsheet-2022.pdf

Public-Health-3.0-White-Paper (1).pdf

C. Staff Updates

23-1517 Children's Program Updates

Attachments: For Board Meeting thank yous.pdf

For Board Meeting parade.pdf

23-1518 Community Partnership Updates

8. Adjournment

Notice is hereby given that a quorum of the Common Council may be present during this meeting, although no Council action will be taken.

Reasonable Accommodations for Persons with Disabilities will be made upon Request and if Feasible.

City of Appleton

100 North Appleton Street
Appleton, WI 54911-4799
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Meeting Minutes
Library Board

Tuesday, December 19, 2023 **4:30 PM** **100 N. Appleton Street**
City Hall Council Chambers, 6th Floor 6 A / B

1. Call meeting to order

President Margret Mann called the meeting to order at 4:31pm

2. Pledge of Allegiance

3. Roll call of membership

Others Present: Owen Anderson, Ann Cooksey, Darrin Gladd, Tina Krueger, Adriana McCleer, Colleen Rortvedt, Tasha Saecker, Kara Sullivan, Maureen Ward

Present: 8 - Looker, Kellner, Scheuerman, Mann, Nett, Van Zeeland, Keller and Brozek

Excused: 3 - Sivasamy, Bunnow and Lee

4. Approval of minutes from previous meeting

23-1507 November 14, 2023 Meeting Minutes

Attachments: 11-14-2023 Library Board Meeting Minutes.pdf

Scheuerman moved, seconded by Van Zeeland, that the November 14, 2023 Meeting Minutes be approved. Roll Call. Motion carried by the following vote:

Aye: 8 - Looker, Kellner, Scheuerman, Mann, Nett, Van Zeeland, Keller and Brozek

Absent: 3 - Sivasamy, Bunnow and Lee

5. Public Participation & Communications

Establish Order of the Day

Kellner moved, seconded by Van Zeeland that Action Items 23-1508, 23-1509, 23-1510, and 23-1511 be placed on a Consent Agenda. Voice Vote. Motion Carried. (8-0)

6. Action Items

Scheuerman moved, seconded by Kellner that the Consent Agenda be approved. Voice Vote. Motion Carried. (8 - 0)

23-1508 Bill Register - November 2023

Attachments: November 23 Bill Register.pdf
APL Financial Cash Flow YTD-November-2023.pdf

This Report Action Item was approved

23-1509 December 2023 Budget Amendment

Attachments: Dec23 Budget Amendment.pdf

This Report Action Item was approved

23-1510 Revised Board Meeting Schedule 2024 - February 27, 2024 5:30pm - 7pm, April 16, 2024 3pm - 4:30pm, May 14, 2024 - 1pm - 2:30pm

Attachments: APL Board Meeting Schedule 2024 REVISED.pdf

This Report Action Item was approved

23-1511 City of Appleton Policies - Code of Conduct Policy, Silica Policy

Attachments: Code of Conduct Draft 11.8.23.pdf
Silica Policy.pdf

This Report Action Item was approved

23-1512 2024 Library Budget

Attachments: Library 2024 Operational Budget.pdf
Library 2024 Special Revenue Funds - Grants.pdf
Library 2024 CIP Self Checks.pdf

Keller moved, seconded by Brozek, that the 2024 Library Budget be approved.
Roll Call. Motion carried by the following vote:

Aye: 8 - Looker, Kellner, Scheuerman, Mann, Nett, Van Zeeland, Keller and Brozek

Absent: 3 - Sivasamy, Bunnow and Lee

7. Information Items

A. Administrative Report

23-1513 Building Project Update

Attachments: 2023_11_BuildingProjectUpdate.pdf
11.2023 - Appleton Public Library Month-End Report.pdf

B. Friends Report

23-1520 Capital Campaign Update

Administrative Report

The Board did not review or discuss any information items on the balance of the Agenda.

23-1514 APL Hiring Process Update

23-1515 Library Legislative Day - Tuesday, February 6, 2024

Attachments: 2024 WLA LLD.pdf

C. President's Report

23-1516 Trustee Development - Public Health Overview

Attachments: FPHS-Factsheet-2022.pdf
Public-Health-3.0-White-Paper (1).pdf

D. Staff Updates

23-1517 Children's Program Updates

23-1518 Community Partnership Updates

23-1519 APL Website Redesign

Attachments: Website Redesign Process Board of Trustees Meeting.pdf

8. Adjournment

Kellner moved, seconded by Scheuerman that the meeting be Adjourned. Voice Vote. Motion Carried. (8-0)

The meeting was adjourned at 4:52pm

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12

ACCOUNT/VENDOR		DOCUMENT	PO	YEAR/PR	TYP	S		CHECK RUN CHECK	DESCRIPTION
16010			Library Administration						
16010	620100			Training/Conferences					
999990	LINKEDIN PRE 8992965	114520	0	2023 12	INV	P	42.19	pcard	LinkedIn Learning P
999990	MARITZ AT&L* ALA	114521	0	2023 12	INV	P	527.00	pcard	2024 PLA Registrati
999990	MARITZ AT&L* ALA	114955	0	2023 12	INV	P	-120.00	pcard	Credit PLA Registra
999990	WISCONSIN LIBRARY AS	114956	0	2023 12	INV	P	45.00	pcard	WLA LLD REGISTRATIO
999990	WISCONSIN LIBRARY AS	114973	0	2023 12	INV	P	45.00	pcard	WLA LLD REGISTRATIO
							539.19		
				ACCOUNT TOTAL			539.19		
16010	630100			Office Supplies					
999990	WALGREENS #12693	114464	0	2023 12	INV	P	18.56	pcard	Candy Bars Staff Re
999990	USPS PO 5602500943	114974	0	2023 12	INV	P	31.92	pcard	Board Packets Posta
							50.48		
				ACCOUNT TOTAL			50.48		
16010	630300			Memberships & Licenses					
999990	WPY*WISCONSIN VOLUNT	113973	0	2023 12	INV	P	26.12	pcard	Membership to WI vo
999990	WISCONSIN LIBRARY AS	114518	0	2023 12	INV	P	250.00	pcard	WLA Membership Rene
999990	AMERLIBASSOC ECOMMER	114519	0	2023 12	INV	P	569.00	pcard	ALA Membership Rene
							845.12		
				ACCOUNT TOTAL			845.12		
16010	630500			Awards & Recognition					
000084	ADI	114465	0	2023 12	INV	P	165.00	pcard	Gift Certificates S
002877	ACOCA	114993	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *APPLETON	114982	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *UNI UNI TEA SHOP	114983	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *ALL TIED UP FLOR	114984	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *SETH'S COFFEE TO	114985	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SP BOARDLANDIA_APPLE	114986	0	2023 12	INV	P	10.00	pcard	SP BOARDLANDIA_APPL
999990	CINDERS CHARCOAL GRI	114987	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *VOYAGEURS BAKEHO	114988	0	2023 12	INV	P	10.00	pcard	Holiday brunch gift
999990	SQ *JOSEF'S GYROS AN	114989	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *DEPAWSITORY: ALL	114990	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *THE BOOK STORE	114991	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *AUTHOR'S KITCHEN	114992	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *WHISK & ARROW SU	114994	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *ECO CANDLE CO.	114995	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SQ *BLUE MOON EMPORI	114996	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	TST* TIPSY TACO	114997	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	TST* SODA BAR LLC	114998	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift
999990	SP ERODING WINDS	114999	0	2023 12	INV	P	10.00	pcard	Holiday Brunch Gift

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12

ACCOUNT/VENDOR		DOCUMENT	PO	YEAR/PR	TYP	S		CHECK RUN	CHECK	DESCRIPTION
							170.00			
				ACCOUNT TOTAL			345.00			
16010	630700			Food & Provisions						
001775	MICHIELS CATERING	114577	0	2023	12	INV P	1,257.25	122023	562144	APL Holiday Breakfa
999990	SQ *COPPER ROCK COFF	114952	0	2023	12	INV P	-1.16	pcard		Books and Brews ref
999990	SQ *COPPER ROCK COFF	114953	0	2023	12	INV P	25.60	pcard		Books and Brews ref
							24.44			
				ACCOUNT TOTAL			1,281.69			
16010	632002			Outside Printing						
999990	DRI*PRINTING SERVICE	114943	0	2023	12	INV P	133.60	pcard		Temporary Location
				ACCOUNT TOTAL			133.60			
16010	641200			Advertising						
002158	CAREERBUILDER	114598	0	2023	12	INV P	77.57	122023	562101	November 2023 Posti
				ACCOUNT TOTAL			77.57			
				ORG 16010	TOTAL		3,272.65			
16021				Library Children's Services						
16021	620100			Training/Conferences						
999990	WISCONSIN LIBRARY AS	113999	0	2023	12	INV P	60.00	pcard		WISCONSIN LIBRARY A
				ACCOUNT TOTAL			60.00			
16021	659900			Other Contracts/Obligation						
001983	AMAZON	115029	0	2023	12	INV P	154.47	pcard		rug
001983	AMAZON	115030	0	2023	12	INV P	144.99	pcard		rug
							299.46			
				ACCOUNT TOTAL			299.46			
				ORG 16021	TOTAL		359.46			
16023				Library Public Services						
16023	630100			Office Supplies						
001983	AMAZON	115028	0	2023	12	INV P	409.86	pcard		Rug
				ACCOUNT TOTAL			409.86			
				ORG 16023	TOTAL		409.86			

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12

ACCOUNT/VENDOR		DOCUMENT	PO	YEAR/PR	TYP	S		CHECK RUN	CHECK	DESCRIPTION
16024				Library Community Partnerships						
16024	630100			Office Supplies						
001983	AMAZON	114891	0	2023 12	INV	P	25.86	pcard		Fender Speaker Cabl
999990	COZZY CORNER	114877	0	2023 12	INV	P	519.93	pcard		NEW North Coworking
999990	SQ *FRIO	114958	0	2023 12	INV	P	66.88	pcard		NEW North Coworking
999990	MICHAELS STORES 8783	114959	0	2023 12	INV	P	58.03	pcard		Supplies for Card M
999990	TST* GINGEROOTZ ASIA	114960	0	2023 12	INV	P	25.00	pcard		NEW North Coworking
							669.84			
				ACCOUNT TOTAL			695.70			
16024	659900			Other Contracts/Obligation						
002575	PARNEE POET	114650	0	2023 12	INV	P	200.00	122023	562163	Co-Working Session
003238	ROBYN SMITH	113822	0	2023 12	INV	P	150.00	121323	562051	Find Your Ancestors
				ACCOUNT TOTAL			350.00			
				ORG 16024 TOTAL			1,045.70			
16031				Library Building Operations						
16031	630600			Building Maint./Janitorial						
001333	TARTAN SUPPLY CO., I	114628	0	2023 12	INV	P	432.21	122023	562179	Tissue, Towels, Dis
002818	ARAMARK	113967	0	2023 12	INV	P	21.41	pcard		Mats, Mops
002818	ARAMARK	114516	0	2023 12	INV	P	21.41	pcard		Mats, Mops
002818	ARAMARK	114954	0	2023 12	INV	P	21.41	pcard		ARAMARK UNIFORM
							64.23			
				ACCOUNT TOTAL			496.44			
16031	640700			Solid Waste/Recycling Pickup						
001593	PFEFFERLE COMPANIES	114045	0	2023 12	INV	P	58.16	121323	562039	December 2023 - Tra
				ACCOUNT TOTAL			58.16			
16031	641301			Electric						
001575	WE ENERGIES	564	0	2023 12	INV	P	1,004.31	010324	562343	0701172433-00287
001593	PFEFFERLE COMPANIES	114683	0	2023 12	INV	P	2,910.12	122023	562165	Nov/Dec - Gas & Ele
				ACCOUNT TOTAL			3,914.43			
16031	641302			Gas						
001575	WE ENERGIES	564	0	2023 12	INV	P	776.53	010324	562343	0701172433-00286
001593	PFEFFERLE COMPANIES	114683	0	2023 12	INV	P	1,389.00	122023	562165	Nov/Dec - Gas & Ele

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12

ACCOUNT/VENDOR		DOCUMENT	PO	YEAR/PR	TYP	S		CHECK RUN	CHECK	DESCRIPTION
					ACCOUNT TOTAL		2,165.53			
16031	644000			Snow Removal Services						
001593	PFEFFERLE COMPANIES	115254	0	2023 12	INV	P	944.00	010324	562328	Snowplowing - Final
001593	PFEFFERLE COMPANIES	115271	0	2023 12	INV	A	7,072.00			Snowplowing - Kensi
							8,016.00			
					ACCOUNT TOTAL		8,016.00			
16031	650200			Leases						
003245	AMERICAN MANAGEMENT	114457	0	2023 12	INV	P	13,489.55	122023	562087	Jan 2024 Lease - Co
					ACCOUNT TOTAL		13,489.55			
16031	659900			Other Contracts/Obligation						
002229	STAR PROTECTION AND	114627	0	2023 12	INV	P	5,068.75	122023	562176	Security Guard - AP
					ACCOUNT TOTAL		5,068.75			
				ORG 16031	TOTAL		33,208.86			
16032				Library Materials Management						
16032	503500			Other Reimbursements						
003263	CITY OF WAUKESHA	113758	0	2023 12	INV	P	16.14	121323	561998	PATRON MATERIAL REI
					ACCOUNT TOTAL		16.14			
16032	620100			Training/Conferences						
000260	CHARLES LATORRE CONS	114720	0	2023 12	INV	P	625.00	122723	562217	MM Staff Training
					ACCOUNT TOTAL		625.00			
16032	630100			Office Supplies						
001393	ULINE	114977	0	2023 12	INV	P	1,585.42	pcard		Carts for WALTCO De
999990	THE HOME DEPOT #4928	113985	0	2023 12	INV	P	12.47	pcard		Supply purchase - w
999990	KAPCO-ONLINE	114978	0	2023 12	INV	P	816.48	pcard		Book jacket covers
999990	THE HOME DEPOT #4928	115005	0	2023 12	INV	P	6.47	pcard		Command adhesive fo
							835.42			
					ACCOUNT TOTAL		2,420.84			
16032	631500			Books & Library Materials						
000889	MIDWEST TAPE	113989	0	2023 12	INV	P	77.66	pcard		504703742, 50470374
000889	MIDWEST TAPE	115011	0	2023 12	INV	P	2,945.62	pcard		561774290
000889	MIDWEST TAPE	115012	0	2023 12	INV	P	-2,945.62	pcard		561834520
000889	MIDWEST TAPE	115013	0	2023 12	INV	P	20.24	pcard		504737359
000889	MIDWEST TAPE	115014	0	2023 12	INV	P	12,818.17	pcard		504720332
							12,916.07			

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12

ACCOUNT/VENDOR		DOCUMENT	PO	YEAR/PR	TYP	S		CHECK RUN	CHECK	DESCRIPTION
001983	AMAZON	113990	0	2023 12	INV	P	-21.99	pcard		113-9943239-8015461
001983	AMAZON	113996	0	2023 12	INV	P	44.34	pcard		112-5854320-9424223
							22.35			
002396	INGRAM LIBRARY SERV	113991	0	2023 12	INV	P	-39.95	pcard		78977149, 78903451
002396	INGRAM LIBRARY SERV	113992	0	2023 12	INV	P	49.49	pcard		78984962
002396	INGRAM LIBRARY SERV	113993	0	2023 12	INV	P	1,346.43	pcard		79026401
002396	INGRAM LIBRARY SERV	113994	0	2023 12	INV	P	219.63	pcard		79050933
002396	INGRAM LIBRARY SERV	114548	0	2023 12	INV	P	-103.99	pcard		79096979, 79067662
002396	INGRAM LIBRARY SERV	114549	0	2023 12	INV	P	170.82	pcard		79100360
002396	INGRAM LIBRARY SERV	114550	0	2023 12	INV	P	47.23	pcard		79117478
002396	INGRAM LIBRARY SERV	114551	0	2023 12	INV	P	448.98	pcard		79162191
002396	INGRAM LIBRARY SERV	114552	0	2023 12	INV	P	497.11	pcard		79192302
002396	INGRAM LIBRARY SERV	115016	0	2023 12	INV	P	454.64	pcard		79336299
							3,090.39			
002830	KANOPY, INC	113724	0	2023 12	INV	P	495.90	121323	562016	Inv. #377422
999990	RISKMANAGEM	113997	0	2023 12	INV	P	572.02	pcard		9000666334-23
999990	THOMSON WEST*TCD	114546	0	2023 12	INV	P	1,097.57	pcard		849343438
999990	CENGAGE GALE	114547	0	2023 12	INV	P	600.00	pcard		83028039
999990	GAN*WINEWSPAPERCIRC	115015	0	2023 12	INV	P	220.47	pcard		postc121423
							2,490.06			
				ACCOUNT TOTAL			19,014.77			
16032	659900			Other Contracts/Obligation						
001398	UNIQUE MANAGEMENT SE	113757	0	2023 12	INV	P	157.60	121323	562066	Collection Agency -
				ACCOUNT TOTAL			157.60			
				ORG 16032 TOTAL			22,234.35			
16033			Library Network Services							
16033	632700			Miscellaneous Equipment						
003011	LIBRARY IDEAS, LLC	114660	0	2023 12	INV	P	6,585.00	122023	562135	Childrens Play Tabl
				ACCOUNT TOTAL			6,585.00			
16033	641800			Equip Repairs & Maint						
000911	MODERN BUSINESS MACH	114663	0	2023 12	INV	P	62.45	122023	562149	Copier Contract - M
999990	MOBILE BEACON	113986	0	2023 12	INV	P	120.00	pcard		MOBILE BEACON
999990	MOBILE BEACON	113987	0	2023 12	INV	P	120.00	pcard		MOBILE BEACON
999990	OPTIMAL WORKSHOP	114506	0	2023 12	INV	P	249.00	pcard		Website Redesign Da
							489.00			

INVOICE LIST BY GL ACCOUNT

YEAR/PERIOD: 2023/12 TO 2023/12 ACCOUNT/VENDOR	DOCUMENT	PO	YEAR/PR	TYP	S	CHECK RUN CHECK	DESCRIPTION	
			ACCOUNT TOTAL			551.45		
			ORG 16033	TOTAL		7,136.45		
FUND 100 General Fund			TOTAL:			67,667.33		

** END OF REPORT - Generated by Melissa E. Sawicki **

Appleton Public Library Cash Flow Report December-2023 Year to Date

GL Account	ACCOUNT DESCRIPTION	ORIGINAL APPROP	REVISED BUDGET	JAN ACTUAL	FEB ACTUAL	MAR ACTUAL	APR ACTUAL	MAY ACTUAL	JUN ACTUAL	JUL ACTUAL	AUG ACTUAL	SEP ACTUAL	OCT ACTUAL	NOV ACTUAL	DEC ACTUAL	YTD TOTAL	% USED
423200	*Library Grants & Aids*	$1,064,805.00	$1,064,805.00	$0.00	$0.00	$0.00	$575,066.50	$0.00	$0.00	$0.00	$489,738.50	$0.00	$0.00	$0.00	$0.00	**$1,064,805.00**	100.0%
480100	*General Charges for Service*	$0.00	$0.00	$12.97	$23.22	$192.06	$7.22	$112.79	$95.21	$11.48	$23.41	$152.85	$117.82	$21.00	$18.69	**$788.72**	100.0%
500100	*Fees & Commissions*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	0.0%
501500	*Rental of City Property*	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	0.0%
502000	*Donations & Memorials*	$0.00	$0.00	$60.36	$1.66	($49.41)	($2.91)	$1.50	$13.42	$3.17	$62.43	$0.54	$1.99	$232.16	$1.00	**$325.91**	100.0%
503500	*Other Reimbursements*	$45,600.00	$108,471.00	$1,546.06	$1,741.58	$64,259.13	$1,203.10	$1,953.05	$4,723.61	$1,252.13	$17,234.86	$1,687.47	$2,321.60	$8,688.69	$8,200.56	**$114,811.84**	105.8%
	Total Revenue	**$1,110,405.00**	**$1,173,276.00**	**$1,619.39**	**$1,766.46**	**$64,401.78**	**$576,273.91**	**$2,067.34**	**$4,832.24**	**$1,266.78**	**$507,059.20**	**$1,840.86**	**$2,441.41**	**$8,941.85**	**$8,220.25**	**$1,180,731.47**	100.6%

	Expense			JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD TOTAL	% USED
610100	*Regular Salaries*	($2,476,082.00)	($2,476,082.00)	($87,823.96)	($177,599.45)	($261,333.77)	($164,551.34)	($170,930.95)	($181,142.23)	($165,204.11)	($253,484.21)	($166,376.67)	($153,700.23)	($157,767.64)	($149,721.42)	**($2,089,635.98)**	84.4%
610400	*Call Time Wages*	$0.00	$0.00	$0.00	$0.00	($75.00)	$0.00	($150.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**($225.00)**	100.0%
610500	*Overtime Wages*	$0.00	$0.00	($364.52)	($755.09)	($208.30)	($208.92)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**($1,536.83)**	100.0%
610800	*Part-Time Wages*	($212,587.00)	($218,587.00)	($9,656.68)	($18,014.79)	($27,301.63)	($17,739.82)	($18,388.91)	($14,359.88)	($16,046.81)	($23,619.92)	($17,528.95)	($21,040.08)	($20,287.82)	($10,709.05)	**($214,694.34)**	98.2%
611400	*Sick Pay*	$0.00	$0.00	$0.00	$0.00	($603.28)	($938.43)	$0.00	$0.00	$0.00	($268.12)	$0.00	$0.00	$0.00	$0.00	**($1,809.83)**	100.0%
611500	*Vacation Pay*	$0.00	$0.00	($9,176.95)	($6,629.58)	($20,481.93)	($23,789.05)	($14,827.13)	($14,493.47)	($23,802.16)	($28,968.31)	($17,742.56)	($20,195.23)	($17,965.75)	($21,636.81)	**($219,708.93)**	100.0%
615000	*Fringes*	($891,233.00)	($891,233.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	0.0%
615100	*FICA*	$0.00	$0.00	($12,752.67)	($12,798.98)	($20,113.27)	($13,269.05)	($13,029.66)	($13,550.77)	($12,973.70)	($19,944.15)	($12,824.82)	($12,209.55)	($12,310.35)	($11,902.19)	**($167,679.16)**	100.0%
615200	*Retirement*	$0.00	$0.00	($12,011.77)	($11,528.60)	($17,866.64)	($11,570.26)	($11,492.16)	($12,292.36)	($11,730.89)	($17,686.01)	($11,273.88)	($10,933.29)	($10,992.01)	($10,735.93)	**($150,113.80)**	100.0%
615301	*Health Insurance*	$0.00	$0.00	($39,927.89)	($39,756.90)	($20,602.34)	($39,315.51)	($39,661.89)	($42,410.28)	($41,491.38)	($41,580.57)	($38,487.68)	($36,319.51)	($36,725.30)	($35,879.72)	**($452,158.97)**	100.0%
615302	*Dental Insurance*	$0.00	$0.00	($2,956.29)	($2,934.60)	($1,349.48)	($2,851.48)	($2,823.46)	($2,961.52)	($2,814.95)	($2,828.28)	($2,636.98)	($2,519.59)	($2,538.76)	($2,478.42)	**($31,693.81)**	100.0%
615400	*Life Insurance*	$0.00	$0.00	($74.10)	($76.50)	($76.50)	($84.90)	($83.88)	($83.40)	($91.80)	($93.70)	($84.20)	($81.10)	($85.90)	($87.60)	**($1,003.58)**	100.0%
	Personnel Services	**($3,579,902.00)**	**($3,585,902.00)**	**($174,744.83)**	**($270,094.49)**	**($370,012.14)**	**($274,318.76)**	**($271,388.04)**	**($281,293.91)**	**($274,155.80)**	**($388,473.27)**	**($266,955.74)**	**($256,998.58)**	**($258,673.53)**	**($243,151.14)**	**($3,330,260.23)**	92.9%

	Expense			JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD TOTAL	% USED
620100	*Training/Conferences*	($23,234.00)	($27,734.00)	($285.00)	($30.00)	($1,753.25)	($912.45)	($1,803.71)	($505.00)	($3,413.14)	($1,913.86)	($1,247.00)	($896.13)	($577.56)	($1,439.56)	**($14,776.66)**	53.3%
620200	*Mileage Reimbursement*	$0.00	$0.00	($387.00)	($387.00)	($387.00)	($387.00)	($455.78)	($500.78)	($387.00)	($387.00)	($60.00)	($60.00)	($116.33)	($120.00)	**($3,634.89)**	100.0%
620600	*Parking Permits*	($5,000.00)	($5,000.00)	$0.00	($383.00)	$0.00	($73.93)	$0.00	$0.00	$0.00	($167.77)	($43.59)	$0.00	($137.43)	($538.00)	**($1,343.72)**	26.9%
630100	*Office Supplies*	($35,517.00)	($46,755.00)	($1,134.08)	($1,921.91)	($2,266.33)	($2,558.93)	($3,002.48)	($1,776.78)	($1,884.14)	($1,641.65)	($2,810.14)	($1,848.81)	($1,302.00)	($3,628.88)	**($25,776.13)**	55.1%
630300	*Memberships & Licenses*	($2,200.00)	($2,200.00)	$0.00	($155.00)	($355.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($52.75)	$0.00	($845.12)	**($1,407.87)**	64.0%
630500	*Awards & Recognition*	($850.00)	($1,850.00)	($691.16)	($10.00)	($1,147.99)	($1,136.00)	($270.62)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($395.21)	**($3,650.98)**	197.4%
630600	*Building Maint./Janitor*	($7,000.00)	($7,000.00)	($1,370.84)	($757.33)	($534.45)	($165.54)	($1,245.19)	($324.65)	($279.24)	($1,307.62)	($683.86)	($473.38)	($270.29)	($496.44)	**($7,908.83)**	113.0%
630700	*Food & Provisions*	($1,135.00)	($5,714.00)	($245.51)	($20.70)	($77.32)	($1,209.21)	($143.29)	($306.97)	($80.25)	($138.10)	($150.80)	($418.39)	($35.90)	($1,281.69)	**($4,108.13)**	71.9%
630902	*Tools & Instruments*	($150.00)	($150.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($69.98)	$0.00	**($69.98)**	46.7%
631500	*Books & Library Materials*	($475,000.00)	($499,156.00)	($44,227.37)	($60,016.85)	($30,210.90)	($33,296.62)	($40,975.41)	($36,682.25)	($29,668.59)	($40,030.16)	($41,172.80)	($38,007.62)	($39,950.02)	($39,305.42)	**($473,544.01)**	94.9%
632001	*City Copy Charges*	($100.00)	($100.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	0.0%
632002	*Outside Printing*	$0.00	($1,200.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($133.60)	**($133.60)**	11.1%
632101	*Uniforms*	$0.00	$0.00	$0.00	$0.00	($161.25)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**($161.25)**	100.0%
632300	*Safety Supplies*	($550.00)	($550.00)	$0.00	($233.76)	$0.00	$385.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($18.99)	**$132.25**	-24.0%
632700	*Miscellaneous Equipment*	($28,630.00)	($30,630.00)	($412.56)	($55.64)	($4,393.69)	$0.00	($111.56)	($1,518.00)	($1,885.85)	($448.65)	($1,179.80)	($7,322.00)	($57.69)	($10,524.94)	**($27,910.38)**	91.1%
640700	*Solid Waste/Recycling Pickup*	($1,200.00)	($1,200.00)	($434.00)	($112.00)	($434.00)	($756.00)	($112.00)	($434.00)	($434.00)	($434.00)	($434.00)	($522.80)	($378.80)	($380.16)	**($4,865.76)**	405.5%
641200	*Advertising*	($1,288.00)	($9,288.00)	($592.90)	($1,867.38)	($164.99)	($267.83)	($926.50)	($495.53)	($1,367.53)	($2,301.77)	($158.96)	($961.15)	($138.25)	($163.75)	**($9,406.54)**	101.3%
641301	*Electric*	($30,000.00)	($30,000.00)	($3,335.17)	($7,746.98)	($12,214.27)	($3,687.03)	($14,251.97)	($4,158.94)	($10,158.72)	($10,301.68)	($5,095.29)	($3,346.95)	($3,544.48)	($3,914.43)	**($81,755.91)**	272.5%
641302	*Gas*	($20,000.00)	($20,000.00)	($3,431.49)	($7,268.52)	($9,709.01)	($1,216.68)	($3,287.06)	($66.62)	($883.44)	($576.32)	($220.43)	($50.36)	($634.96)	($2,165.53)	**($29,510.42)**	147.6%
641303	*Water*	$0.00	$0.00	$0.00	($185.00)	$0.00	$0.00	($185.00)	$0.00	$0.00	($234.95)	$0.00	$0.00	($136.90)	$0.00	**($741.85)**	100.0%
641304	*Sewer*	$0.00	$0.00	$0.00	($51.00)	$0.00	$0.00	($54.55)	$0.00	$0.00	($69.28)	$0.00	$0.00	($40.37)	$0.00	**($215.20)**	100.0%
641306	*Stormwater*	$0.00	$0.00	$0.00	($793.97)	$0.00	$0.00	($776.71)	$0.00	$0.00	($793.97)	$0.00	$0.00	($785.34)	$0.00	**($3,149.99)**	100.0%
641307	*Telephone*	($5,298.00)	($5,298.00)	$0.00	($905.74)	($554.89)	($194.98)	($920.74)	($563.13)	($561.55)	($555.48)	($389.96)	($727.28)	($568.62)	($565.55)	**($6,507.92)**	122.8%
641308	*Cellular Phones*	($1,300.00)	($1,300.00)	($103.75)	$0.00	($207.50)	($103.75)	($103.75)	($103.75)	$0.00	($207.50)	($103.75)	($25.09)	($62.25)	$0.00	**($1,021.09)**	78.5%
641600	*Build Repairs & Maint*	($2,000.00)	($2,000.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	0.0%
641800	*Equip Repairs & Maint*	($49,255.00)	($49,255.00)	($2,602.74)	($399.74)	($11,287.11)	($1,526.32)	($2,668.45)	($402.80)	($2,001.94)	($1,576.88)	($581.30)	($3,067.44)	($8,562.60)	($2,999.27)	**($37,676.59)**	76.5%
642000	*Facilities Charges*	($100,565.00)	($100,565.00)	$0.00	($66.84)	($5,671.50)	($66.84)	($3,722.80)	($2,881.42)	($66.84)	($6,523.32)	($3,576.17)	($9,096.60)	($2,577.22)	$0.00	**($34,249.55)**	34.1%
644000	*Snow Removal Services*	($50,000.00)	($50,000.00)	$0.00	$0.00	$0.00	($64,177.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($8,016.00)	**($72,193.00)**	144.4%
650200	*Leases*	($150,000.00)	($150,000.00)	($12,500.00)	($12,500.00)	($12,500.00)	($12,500.00)	($25,000.00)	($12,500.00)	($12,500.00)	($12,500.00)	($12,500.00)	($12,500.00)	($28,826.65)	($13,489.55)	**($179,816.20)**	119.9%

659900	***Other Contracts/Obligation***	($118,817.00)	($136,073.00)	($2,100.00)	($14,924.11)	($64,612.70)	($3,334.32)	($3,243.75)	($7,911.55)	($6,586.05)	($13,954.62)	($7,258.35)	($11,680.50)	($11,750.75)	($6,275.80)	**($153,632.50)**	112.9%
681500	***Software Acquisition***	($4,498.00)	($4,498.00)	($40.00)	($3,374.31)	($1,071.78)	($742.50)	($6,004.35)	($5,335.50)	$0.00	($80.00)	($3,827.80)	($1,681.13)	($80.00)	$0.00	**($22,237.37)**	494.4%
	Operating Expense	**($1,113,587.00)**	**($1,187,516.00)**	**($73,893.57)**	**($114,166.78)**	**($159,714.93)**	**($127,927.93)**	**($109,265.67)**	**($76,467.67)**	**($72,158.28)**	**($96,144.58)**	**($81,494.00)**	**($92,738.38)**	**($100,604.39)**	**($96,697.89)**	**($1,201,274.07)**	101.2%
	Personnel Services	($3,579,902.00)	($3,585,902.00)	($174,744.83)	($270,094.49)	($370,012.14)	($274,318.76)	($271,388.04)	($281,293.91)	($274,155.80)	($388,473.27)	($266,955.74)	($256,998.58)	($258,673.53)	($243,151.14)	**($3,330,260.23)**	
	Operating Expense	($1,113,587.00)	($1,187,516.00)	($73,893.57)	($114,166.78)	($159,714.93)	($127,927.93)	($109,265.67)	($76,467.67)	($72,158.28)	($96,144.58)	($81,494.00)	($92,738.38)	($100,604.39)	($96,697.89)	**($1,201,274.07)**	
	Total Expense	**($4,693,489.00)**	**($4,773,418.00)**	**($248,638.40)**	**($384,261.27)**	**($529,727.07)**	**($402,246.69)**	**($380,653.71)**	**($357,761.58)**	**($346,314.08)**	**($484,617.85)**	**($348,449.74)**	**($349,736.96)**	**($359,277.92)**	**($339,849.03)**	**($4,531,534.30)**	
	Total Revenue	**$1,110,405.00**	**$1,173,276.00**	**$1,619.39**	**$1,766.46**	**$64,401.78**	**$576,273.91**	**$2,067.34**	**$4,832.24**	**$1,266.78**	**$507,059.20**	**$1,840.86**	**$2,441.41**	**$8,941.85**	**$8,220.25**	**$1,180,731.47**	

MAJOR PROJECT TITLE
****** Library - Friends of the Library

PROJECT TITLE
LIB-FRIENDLibrary - Friends of the Library

BEGINNING BALANCE -10,835.45

FUNDING SOURCES			TITLE	AMOUNT
LIB-FRIEND.COMMPART	.OTHREIMB	.	Community Partnerships	-7,081.30
LIB-FRIEND.LIBADMIN	.OTHREIMB	.	Library Administration	-7,500.00
			FUNDING SOURCE TOTAL	-14,581.30

EXPENSE STRINGS			TITLE	AMOUNT
LIB-FRIEND.CHILDSERV	.OTHCONTR	.	Children's Services	1,286.56
LIB-FRIEND.CHILDSERV	.SUPPLIES	.	Children's Services	400.58
LIB-FRIEND.COMMPART	.OTHCONTR	.	Community Partnerships	1,400.00
LIB-FRIEND.COMMPART	.PTWAGES	.	Community Partnerships	3,412.93
LIB-FRIEND.COMMPART	.SUPPLIES	.	Community Partnerships	105.00
LIB-FRIEND.LIBADMIN	.ADVERTISNG	.	Library - Friends advertising	905.48
LIB-FRIEND.LIBADMIN	.AWARDREC	.	Library Administration	50.21
LIB-FRIEND.LIBADMIN	.FOOD/PROV	.	Library Administration	1,412.08
LIB-FRIEND.LIBADMIN	.MEMBERLIC	.	Library Administration	26.12
			EXPENSE TOTAL	8,998.96

ENDING BALANCE -16,417.79

****** TOTALS

BEGINNING BALANCE	-10,835.45
FUNDING SOURCE	-14,581.30
EXPENSE	8,998.96
ENDING BALANCE	-16,417.79

REPORT TOTAL: -16,417.79

** END OF REPORT - Generated by Melissa E. Sawicki **

CITY OF APPLETON
BUDGET AMENDMENT REQUEST
Budget Year 2023

	ORG	OBJECT	PROJ (in GL)		
Description	**PROJECT**	**SEG 1**	**SEG 2**	**SEG 3**	***Amount***
Children's Services - Other Reim	**16021**	**503500**			**$ 200**
Childrens: Supplies	16021	630100			$ 200

For the purpose of:

*OWLS Reimbursement - Charlie & the Chocolate Factory Grant Reimbursement 2023

Requested by:

Department Head _____ Date _____

Information: **Action:**

Finance Director _____ Date _____

Mayor _____ Date _____

Reported to Finance Committee: _____ Date _____ Date

Finance comments:

Budget Entry (BE) No.:_____

BOLDT®
BUILD BOLDLY

December 2023

DECEMBER REPORT

City of Appleton – Appleton Public Library

KEY PROGRESS POINTS

- The Appleton Public Library project team won 2nd place in the Boldt Decorating Contest, with the Wisconsin Christmas Theme, in the job trailer!

- Recycling Program:
  - Boldt continues to recycle items, as necessary.
  - Weights to date of all metals are 354,845lbs.

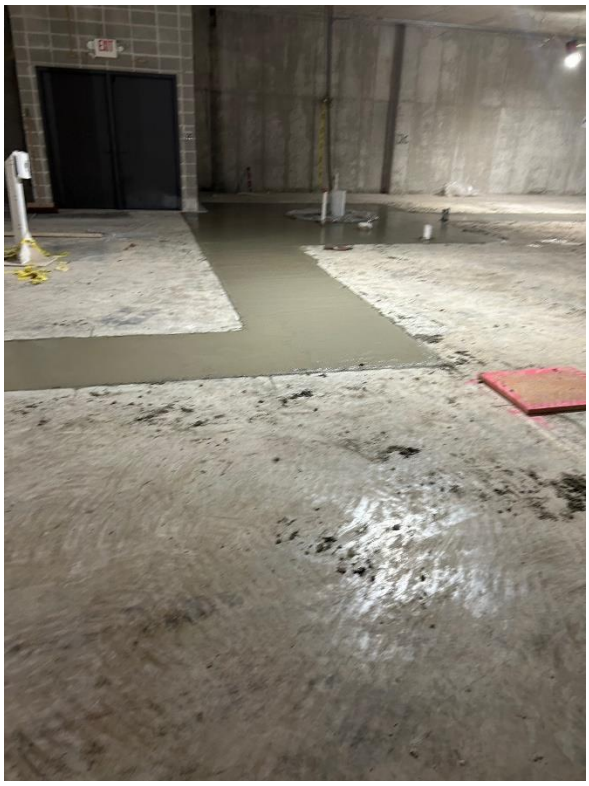
- Progress:
  - Concrete was poured at Lower Level at electrical and plumbing trenches.
  - Continued with demolition at freight elevator, West façade, and Northeast façade.
  - Started scanning floors for rebar locations at all thru-floor penetrations.
  - Continuing select roof demolition for steel install at over-build.
  - Concrete slab cutting at Lower Level for freight elevator was completed.
  - Underpinning continues to be ongoing at passenger and freight elevator locations.
  - Iron workers will be starting to install steel for the freight elevator and West skylight.
  - Began exterior window in-fills.
  - Installed steel and pour-in concrete at demoed ductwork at floor openings.
  - Began reinforcing steel beams at Upper Level.
  - Layout for walls on Ground and Upper floors completed. Began the insulation install of upper and lower track, and MEP layout openings in-walls for framing.
  - Began installing door frames on Ground Level.
  - Completed excavating and forming of footings for addition.
  - Starting to form piers and foundation walls for addition.

CONDITIONS & SAFETY

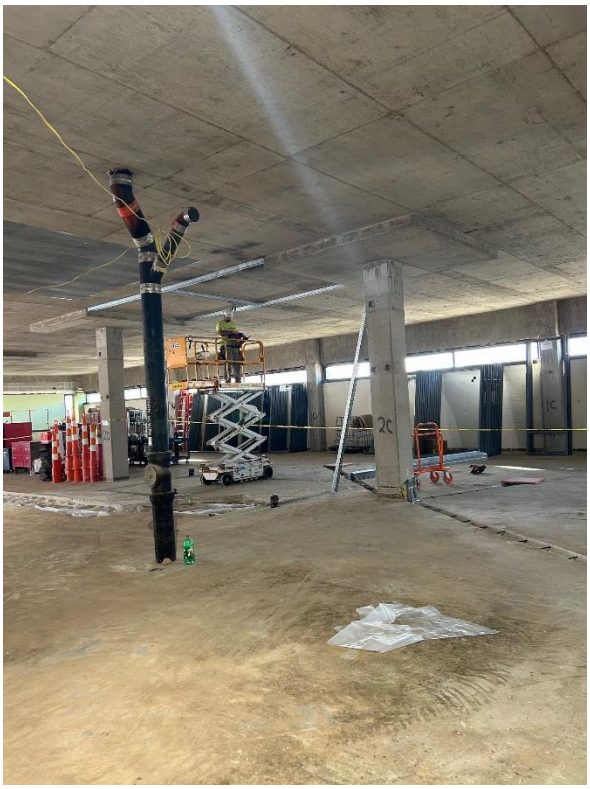
- Site conditions still remain very good. Continuously monitoring our safety program and making sure workers and the general public are safe.
- There were no injuries this month.

PROGRESS PHOTOS

Lower Level – Plumbing Trench



Lower Level – Plumbing Trench

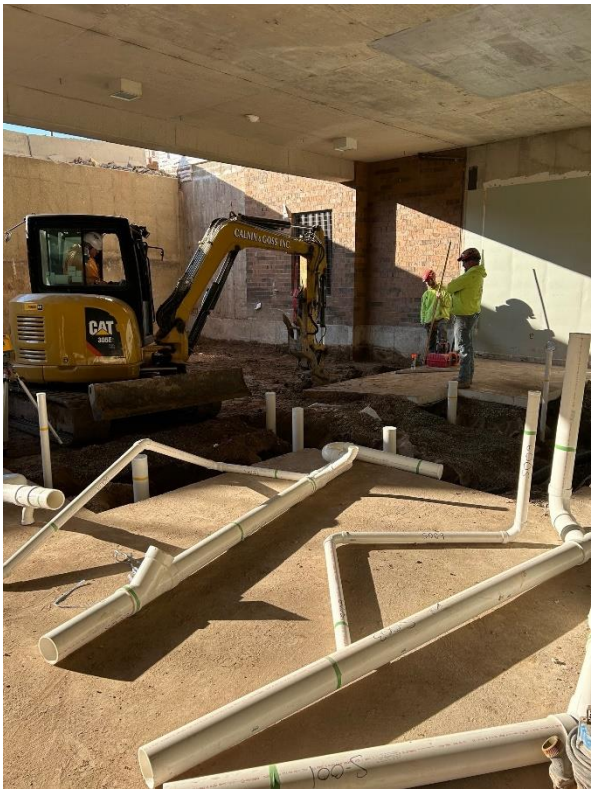


Ground Level - Upper Track Install

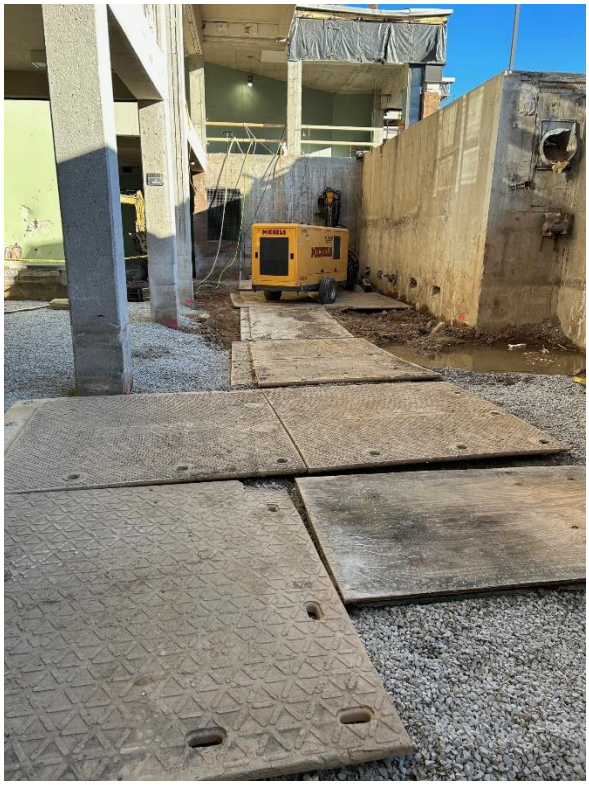
CMU Mock-Up

PROGRESS PHOTOS

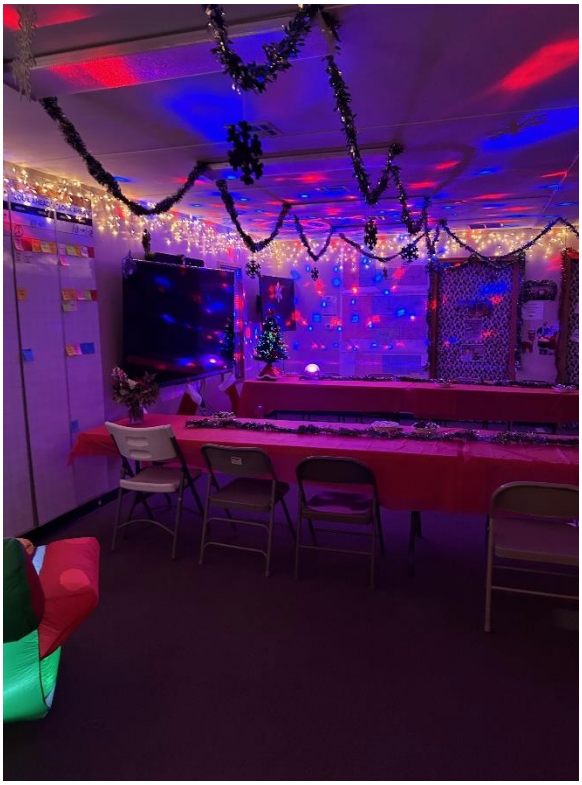
Lower Level - Sump Pit



Lower-Level Atrium - Plumbing



Atrium – Michels Underpinning



Trailer Christmas Decorations

WISCONSIN LIBRARY ASSOCIATION

Registration Open for Library Legislative Day 2024

Tuesday, February 6, 2024

Morning briefing at the Best Western Premier Park Hotel followed by legislator visits

Join us in Madison for a day of advocating for Wisconsin libraries! This year's event will kick off with a briefing at the Best Western Premier Park Hotel (22 S Carroll St, Madison, WI 53703), followed by visits with legislators at the Wisconsin State Capitol.

Once you register for this event, Library Legislative Day committee members will make appointments with legislators and develop the day's schedule for you. The schedule will be shared with attendees a few days in advance of the event.

Watch the WLA Library Legislative Day webpage for additional information as plans are finalized.

Need hotel accommodations? A courtesy block of rooms has been reserved at the Best Western Premier Park Hotel in downtown Madison through January 15, 2024. See below for more information.

Start gathering your photos & preparing your library stories to share with your legislators - and register today! **Online registration will close January 12, 2024.**

Additional Resources

Find Your Representatives

Visit the Wisconsin State Legislature website and enter your address: click here.

Lodging

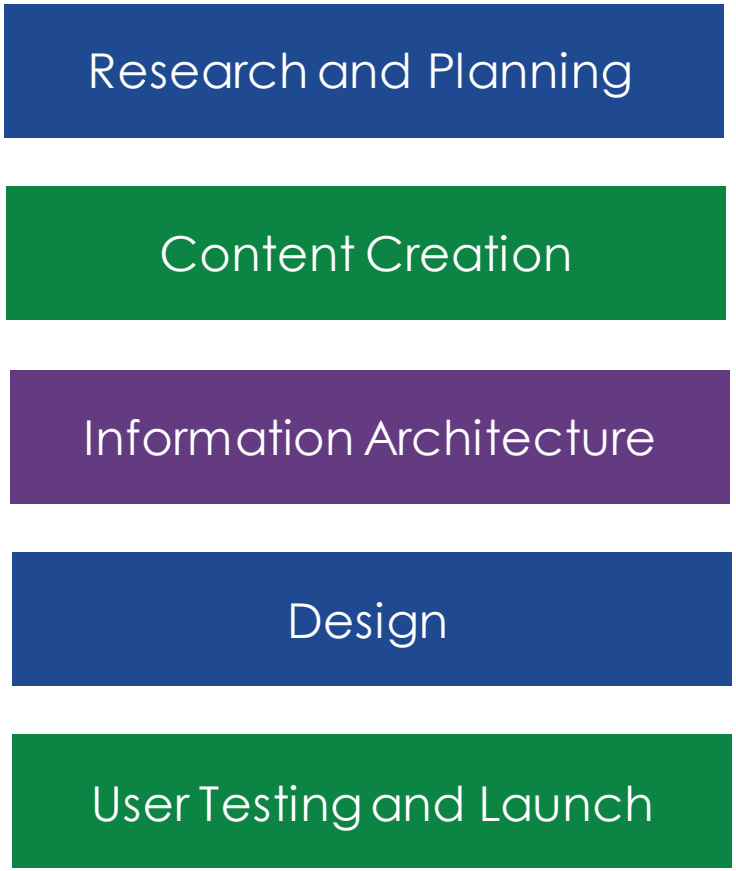
We have reserved a block of rooms at the Best Western Premier Park Hotel. Special group rates for the WI Library Association lodging accommodations on February 5 at the Park Hotel are:

- $149.00 for traditional rooms with one or two beds
- $159.00 for deluxe rooms with one or two beds
- $199.00 for king suites.

Room rates are currently subject to 5.5% state tax and 10% city tax. Cutoff date for room reservations is January 15, 2024.
Click here to access the WLA 2024 Library Legislative Day Room Block.
For information about other hotel options in the downtown Madison area, click here and here.

WISCONSIN LIBRARY ASSOCIATION
PO Box 6437 | 112 Owen Road #6437 | Monona, WI 53716
608.245.3640
wla@wisconsinlibraries.org

Website Redesign Process



Research and Planning

Primary Audience: Public

Uses the website to...

- Get to the catalog/find materials
- Find current hours
- Use calendar/find information about programs
- Use online resources (elibrary)
- Find current library information (address, building project information)

Challenges...

- Navigation/Finding Information
- Catalog
- Calendar

Research and Planning

Secondary Audience: Staff

Uses the website to...

- use calendar/find information about programs
- connecting patrons to information
- helping patrons navigate site
- find online resource information
- get to the catalog/find materials

Challenges...

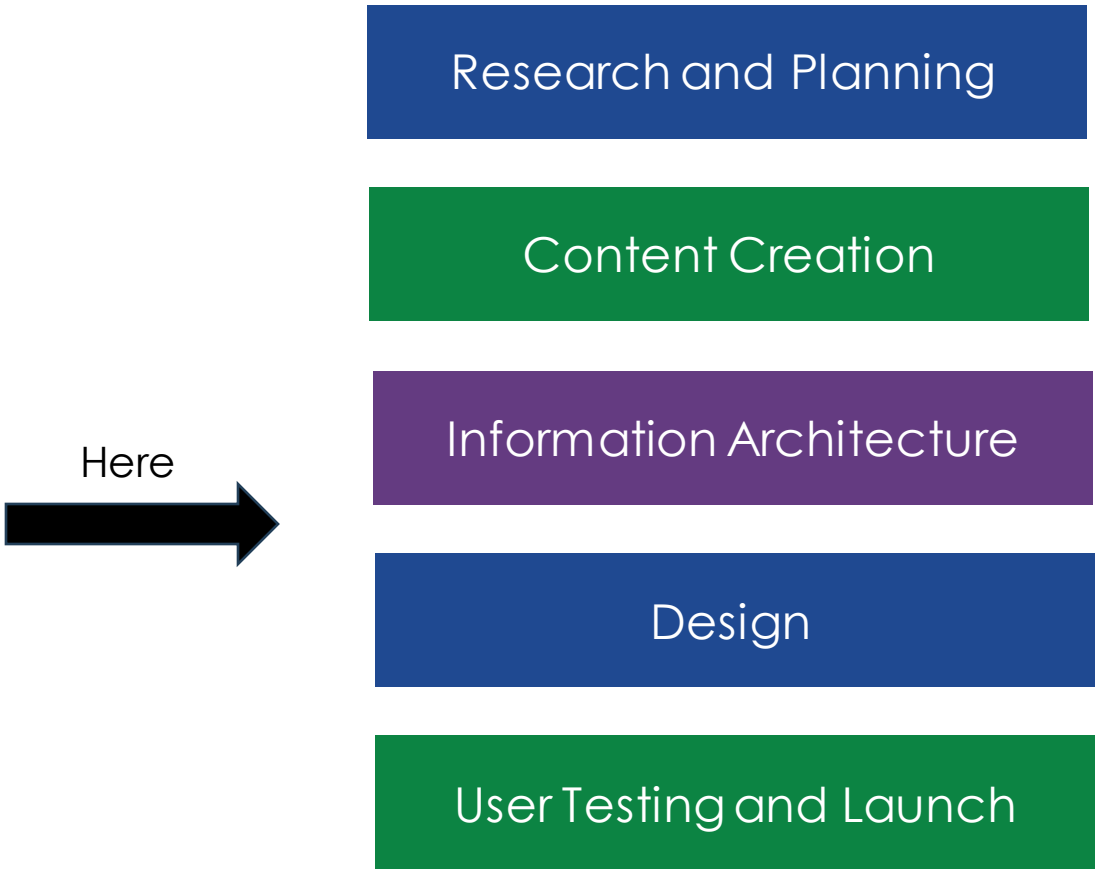
- Navigation/Finding Information
- Repeating Content/Too Much Information
- Outdated Information

Research and Planning

Goals and Guideposts

- Improve the organization, navigation and searching functions.
- Become a model for accessibility.
- Reduce the number of pages and complexity of the existing site.
- Standardize the look and feel of website pages.
- Create consistency in tone and language across the site.
- Reflect the experience of a modern, 21st century library.

Where we are in the process



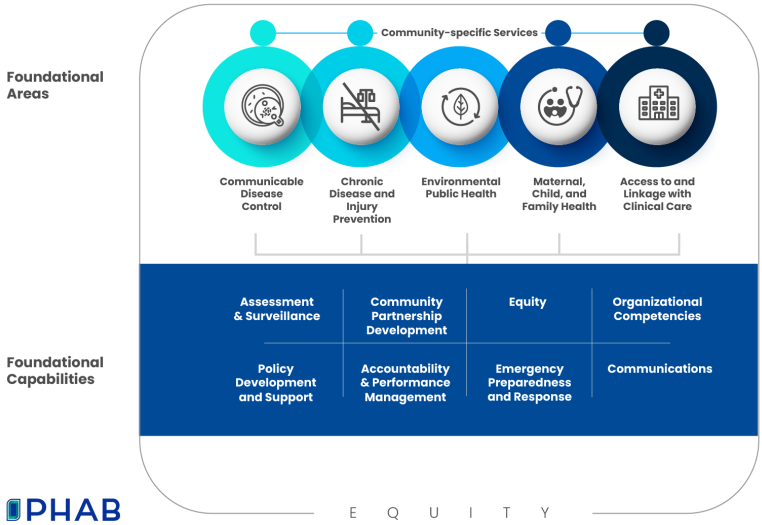
Foundational Public Health Services

Health departments have a fundamental responsibility to provide public health protections and services in a number of areas, including: preventing the spread of communicable disease; ensuring food, air, and water quality are safe; supporting maternal and child health; improving access to clinical care services; and preventing chronic disease and injury. In addition, public health departments provide local protections and services specific to their community's needs.

Health departments serve their communities 24/7 and require access to a wide range of critical data sources, robust laboratory capacity, preparedness and policy planning capacity, partnerships with community, and expert staff to leverage them in support of public health protections.

The Foundational Public Health Services framework outlines the unique responsibilities of governmental public health and defines a minimum set of Foundational Capabilities and Foundational Areas that must be available in every community.

Foundational Public Health Services Framework



Community-specific Services are local protections and services that are unique to the needs of a community. These services are essential to that community's health and vary by jurisdiction.

Foundational Areas

Public health programs, or Foundational Areas, are basic public health, topic-specific programs and services aimed at improving the health of the community. The Foundational Areas reflect the minimum level of service that should be available in all communities.

Foundational Capabilities

Public health infrastructure consists of Foundational Capabilities that are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being and achieving equitable outcomes.

Foundational Capabilities

There are eight Foundational Capabilities that are needed in Public Health Infrastructure.

Assessment & Surveillance

- Ability to collect timely and sufficient foundational data to guide public health planning and decision making at the state and local level, including the personnel and technology that enable collection.
- Ability to collect, access, analyze, interpret, and use data from a variety of sources including granular data and data disaggregated by geography (e.g., census tract, zip code), sub-populations, race, ethnicity, and other variables that fully describe the health and well-being of a community and the factors that influence health.
- Ability to assess and analyze disparities and inequities in the distribution of disease and social determinants of health, that contribute to higher health risks and poorer health outcomes.
- Ability to prioritize and respond to data requests and translate data into information and reports that are valid, complete, statistically accurate, and accessible to the intended audiences.
- Ability to conduct a collaborative community or statewide health assessment and identify health priorities arising from that assessment, including analysis of root causes of health disparities and inequities.
- Ability to access 24/7 laboratory resources capable of providing rapid detection.
- Ability to participate in or support surveillance systems to rapidly detect emerging health issues and threats.
- Ability to work with community partners to collect, report and use public health data that is relevant to communities experiencing health inequities or ability to support community-led data processes.

Community Partnership Development

- Ability to create, convene, support, and sustain strategic, non-program specific relationships with key community groups or organizations representing populations experiencing health disparities or inequities; private businesses and health care organizations; relevant federal, Tribal, state, and local government agencies; elected and non-elected officials.
- Ability to leverage and engage partnerships and community in equity solutions.
- Ability to establish and maintain trust with and authentically engage community members and populations most impacted by inequities in key public health decision-making and use community-driven approaches.
- Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect community members of the health department's jurisdiction.
- Ability to engage members of the community and multi-sector partners in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities. The community health improvement plan can serve as the basis for coordination of effort and resources across partners.

Equity

- Ability to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity.
- Ability to systematically integrate equity into each aspect of the FPHS, strategic priorities, and include equity-related accountability metrics into all programs and services.
- Ability to work collaboratively across the department and the community to build support for and foster a shared understanding of the critical importance of equity to achieve community health and well-being.
- Ability to develop and support staff to address equity.
- Ability to create a shared understanding of what creates health including structural and systemic factors that produce and reproduce inequities.

Organizational Competencies

- **Leadership & Governance:** Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction for public health initiatives, including the advancement of equity. Ability to prioritize and implement diversity, equity, and inclusion within the organization. Ability to engage with appropriate governing entities about the department's public health legal authorities and what new laws and policies might be needed. Ability to ensure diverse representation on public health boards and councils.
- **Information Technology Services, including Privacy & Security:** Ability to maintain and procure the hardware and software needed to access electronic health information to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies and systems needed to interact with community members. Ability to have the proper systems and controls in place to keep health and human resources data confidential and maintain security of IT systems.
- **Workforce Development & Human Resources:** Ability to develop and maintain a diverse and inclusive workforce with the cross-cutting skills and competencies needed to implement the FPHS effectively and equitably. Ability to manage human resource functions including recruitment, retention, and succession planning; training; and performance review and accountability.
- **Financial Management, Contract, & Procurement Services, including Facilities and Operations:** Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations. Ability to leverage funding and ensure resources are allocated to address equity and social determinants of health.
- **Legal Services & Analysis:** Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process

Policy Development and Support

- Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based and grounded in law. This includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.
- Ability to effectively inform and influence policies being considered by other governmental and non-governmental agencies that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.
- Ability to effectively advocate for policies that address social determinants of health, health disparities and equity.
- Ability to issue, promote compliance with or, as mandated, enforce compliance with public health regulations.

Accountability & Performance Management

- Ability to perform according to accepted business standards in accordance with applicable federal, state, and local laws and policies and assure compliance with national and Public Health Accreditation Board Standards.
- Ability to maintain a performance management system to monitor achievement of organizational objectives.
- Ability to identify and use evidence-based or promising practices when implementing new or revised processes, programs and/or interventions.
- Ability to maintain an organization-wide culture of quality and to use quality improvement tools and methods.
- Ability to create accountability structures and internal and external equity-related metrics to measure the equity impact of a department's efforts and performance.

Emergency Preparedness and Response

- Ability to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, and to address a range of events including natural or other disasters, communicable disease outbreaks, environmental emergencies, or other events, which may be acute or occur over time.
- Ability to integrate social determinants of health, and actions to address inequities, including ensuring the protection of high-risk populations, into all plans, programs, and services.
- Ability to lead the Emergency Support Function 8 — Public Health & Medical for the county, region, jurisdiction, and state.
- Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders, and private sector and non-profit partners; and operate within, and as necessary lead, the incident management system.
- Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response.
- Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster, emergency, or public health event.
- Ability to issue and enforce emergency health orders.
- Ability to be notified of and respond to events on a 24/7 basis.
- Ability to access and utilize a Laboratory Response Network (LRN) Reference laboratory for biological agents and an LRN chemical laboratory at a level designated by CDC.

Communications

- Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- Ability to effectively use social media to communicate directly with community members.
- Ability to appropriately tailor communications and communications mechanisms for various audiences.
- Ability to write and implement a routine communications plan and develop routine public health communications including to reach communities not traditionally reached through public health channels.
- Ability to develop and implement a risk communication strategy for communicating with the public during a public health crisis or emergency. This includes the ability to provide accurate and timely information and to address misconceptions and misinformation, and to assure information is accessible to and appropriate for all audiences.
- Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis.
- Ability to develop and implement a proactive health education/health communication strategy (distinct from risk communication) that disseminates timely and accurate information to the public designed to encourage actions to promote health in culturally and linguistically appropriate formats for the various communities served, including using electronic communication tools.

Foundational Areas

There are five Foundational Areas, also known as Public Health Programs. Social determinants of health and actions to address health inequities should be integrated throughout all activities.

Communicable Disease Control

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.
- Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.
- Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to Centers for Disease Control and Prevention (CDC) guidelines.
- Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.
- Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.
- Coordinate and integrate categorically-funded communicable disease programs and services.

Chronic Disease & Injury Prevention

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives.
- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Environmental Public Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.
- Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.
- Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.
- Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.
- Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).
- Coordinate and integrate categorically-funded environmental public health programs and services.

Maternal, Child and Family Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.
- Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.
- Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.
- Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.
- Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Access to & Linkage with Care

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.
- Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.
- In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.

Public Health 3.0

A Call to Action to Create a 21st Century Public Health Infrastructure

Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services

PUBLIC HEALTH 3.0

Table of Contents

Letter from the Acting Assistant Secretary for Health

We have made great strides in the last several years to expand health care coverage and access to medical care and preventive services, but these successes have not yet brought everyone in America to an equitable level of improved health. Today, a person's zip code is a stronger determinant of health than their genetic code. In a nation as wealthy as the United States, it is unconscionable that so many people die prematurely from preventable diseases; even worse are the health disparities that continue to grow in many communities.

High-quality health care is essential for treatment of individual health conditions, but it is not the only tool at our disposal. In order to solve the fundamental challenges of population health, we must address the full range of factors that influence a person's overall health and well-being. From education to safe environments, housing to transportation, economic development to access to healthy foods—the social determinants of health are the conditions in which people are born, live, work, and age.

Public Health 3.0 recognizes that we need to focus on the social determinants of health in order to create lasting improvements for the health of everyone in America. Public health is what we do together as a society to ensure the conditions in which everyone can be healthy. We often think of the health care industry when we think of health, but building healthy communities requires strategic collaboration across all sectors. When we build a complete infrastructure of healthy communities, we can begin to close the gaps in health due to race or ethnicity, gender identity or sexual orientation, zip code or income.

For Public Health 3.0 to succeed, local and state public health leaders must step up to serve as Chief Health Strategists for their communities, mobilizing community action to strengthen infrastructure and form strategic partnerships across sectors and jurisdictions. These partnerships are necessary to develop and share sustainable resources and to leverage data for action that can address the most urgent community health needs.

Public Health 3.0 exemplifies the transformative success stories that many pioneering communities across the country have already accomplished. The challenge now is to institutionalize these efforts and replicate these triumphs across all communities for all people.

Our collaborative action must ensure, for the first time in history, that every person in America has a truly equal opportunity to enjoy a long and healthy life. This report outlines the initial steps we can take to get there. I hope you will join me in Public Health 3.0.

Sincerely,

Karen B. DeSalvo, MD, MPH, MSc
Assistant Secretary for Health (acting)
U.S. Department of Health and Human Services

Executive Summary

Public health is what we do together as a society to ensure the conditions in which everyone can be healthy. Though there are many important sectors and institutions with a key role to play, the governmental public health infrastructure is an essential part of a strong public health system. But local public health agencies have been under extreme stress due to significant funding reductions during the Great Recession, changing population health challenges, and in certain circumstances changes brought on by the Affordable Care Act (ACA). In addition, they are increasingly working with others in the broader health system to address the social determinants of health in response to the mounting data on disparities by race/ethnicity, gender identity or sexual orientation, interpersonal violence and trauma, income, and geography.

To meet these new challenges head on, local public health has been reinventing itself in partnership with others in their communities, and is undergoing a transformation into a new model of public health we call Public Health 3.0 (PH3.0). In this model, pioneering local public health agencies are building upon their historic success at health improvement and are adding attention to the social determinants of health—the conditions in the social, physical, and economic environment in which people are born, live, work, and age [1] —in order to achieve health equity. They do this through deliberate collaboration across both health and non-health sectors, especially with non-traditional partners, and, where appropriate, through assuming the role of Chief Health Strategist in their communities.

In 2016, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health (OASH) launched an initiative to lay out the vision for this new model of public health, to characterize its key components, and to identify what actions would be necessary to better support the emergence of this transformed approach to public health, with particular attention to the efforts needed to strengthen the local governmental public health infrastructure as a critical and unique leader in advancing community health and well-being.

To learn more, OASH visited five communities that are aligned with the PH3.0 vision. In these regional listening sessions, local leaders shared their strategies and exchanged ideas for moving PH3.0 forward. Attendees represented a diverse group of people working in public health and other fields, including philanthropy and nonprofit organizations, businesses, social services, academia, the medical community, state and local government agencies, transportation, and environmental services.

This report summarizes key findings from these regional dialogues and presents recommendations to carry PH3.0 forward, organized in the following five themes:

1. Strong leadership and workforce
2. Strategic partnerships
3. Flexible and sustainable funding
4. Timely and locally relevant data, metrics, and analytics
5. Foundational infrastructure

Recommendations

Based upon what we have heard and seen from the field, we put forth the following set of recommendations to realize the PH3.0 vision for all communities in the United States:

1. Public health leaders should embrace the role of **Chief Health Strategist for their communities**—working with all relevant partners so that they can drive initiatives including those that explicitly address "upstream" social determinants of health. Specialized Public Health 3.0 training should be available for those preparing to enter or already within the public health workforce.

2. Public health departments should engage with community stakeholders—from both the public and private sectors—to form vibrant, **structured, cross-sector partnerships** designed to develop and guide Public Health 3.0–style initiatives and to foster shared funding, services, governance, and collective action.

3. Public Health Accreditation Board (PHAB) criteria and processes for department **accreditation should be enhanced** and supported so as to best foster Public Health 3.0 principles, as we strive to ensure that every person in the United States is served by nationally accredited health departments.

4. Timely, reliable, granular (i.e., sub-county), and **actionable data** should be made accessible to communities throughout the country, and clear **metrics** to document success in public health practice should be developed in order to guide, focus, and assess the impact of prevention initiatives, including those targeting the social determinants of health and enhancing equity.

5. **Funding for public health should be enhanced and substantially modified**, and innovative funding models should be explored so as to expand financial support for Public Health 3.0–style leadership and prevention initiatives. Blending and braiding of funds from multiple sources should be encouraged and allowed, including the recapturing and reinvesting of generated revenue. Funding should be identified to support core infrastructure as well as community-level work to address the social determinants of health.

Introduction

Progress on Health Improvement

The United States has made enormous progress during the past century in improving the health and longevity of its population through effective public health actions and sizable investments in evidence-based preventive services and high-quality clinical care. In 2014, life expectancy at birth was 78.8 years, 10 years longer in lifespan than the 1950s.[2] Smoking rates among adults and teens are less than half what they were 50 years ago.[3] The Affordable Care Act (ACA) has dramatically expanded health insurance coverage, reducing the uninsurance rate to a historic low of of 9.1% in 2015, 16.2 million fewer uninsured Americans than in 2013.[4] Continuous health insurance reform efforts have also driven improvement in health care quality and have slowed the growth rate of health care costs.

Significant Health Gaps Remain

However, despite nearly $3.0 trillion in annual health care spending—almost twice as much as a percentage of gross domestic product as the rest of the world—Americans have shorter lifespans and fare worse in many health indicators, including obesity and diabetes, adolescent pregnancy, drug abuse-related mortality, vaccination rates, injuries, suicides, and homicides.[5] The Centers for Disease Control (CDC) recently reported that the historical steady gain in longevity in the United States has plateaued for three years in a row.[6] Further, race/

ethnicity disparities persist in life expectancy, vaccination rates, infant mortality,[7] and exposure to pollutants.[8] Many of these vexing challenges require solutions outside of the health care system, and require more broad-based actions at the community level.

Figure 1
Short Distances to Large Gaps in Health

Source: Chapman DA, Kelly L, Woolf SH. Life Expectancy Maps. 2015-2016. VCU Center on Society and Health. http://www.societyhealth.vcu.edu/maps

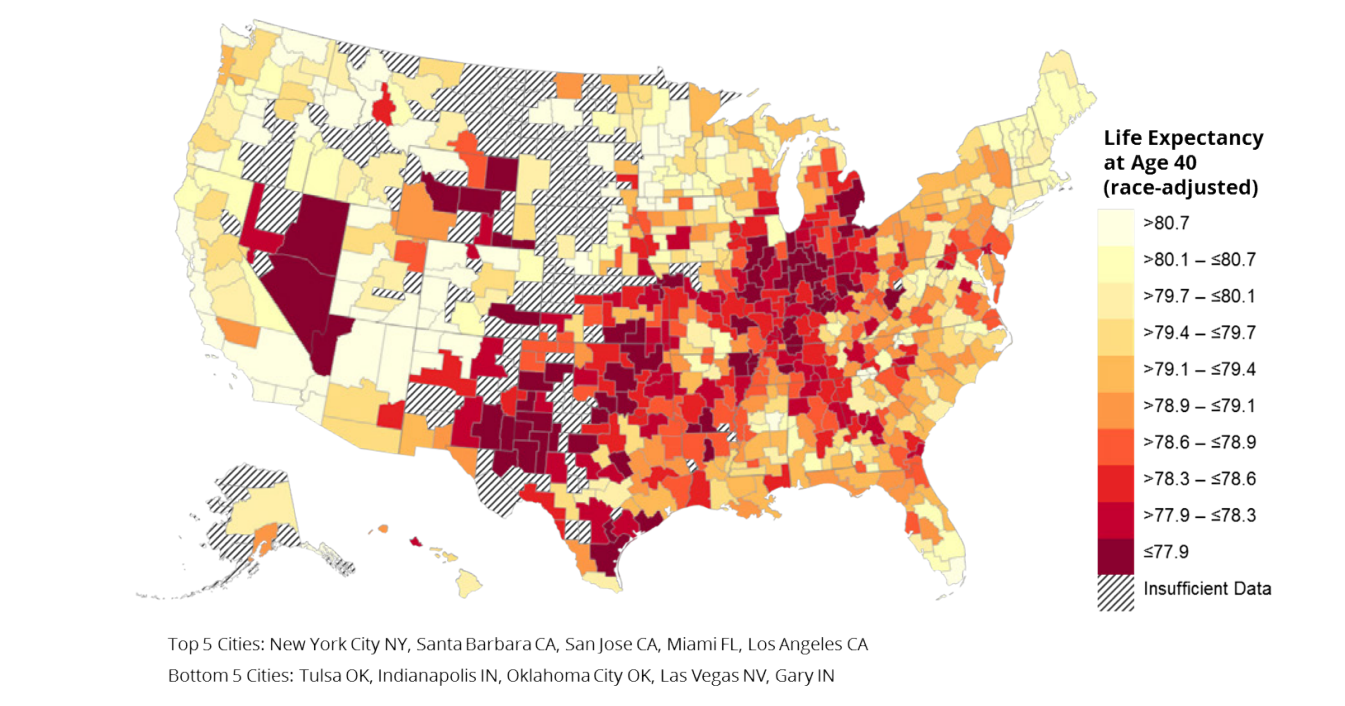
Key Influence of Social Determinants of Health

The lifespan of people living in different parts of the country is a powerful reminder that the opportunity to be healthy often depends more on one's zip code than one's genetic code. Researchers (Figure 2) found that the gap in life expectancy between people with the highest and lowest incomes is narrower in some communities but wider in others. Their data showed significant variations in life expectancy and health risks across different regions in the country.[9] Even within a city, life expectancy can vary by neighborhood. Mapping life expectancies in several cities across the United States, researchers illustrated that in some cases, life expectancy can differ by as much as 20 years in neighborhoods just a few miles apart from one another. These data suggest that investing in safe and healthy communities matters, especially for the most disadvantaged persons.[10] Achieving the goal of Healthy People requires addressing social determinants of health, which includes both social and physical environments where people are born, live, work, and age.

Meanwhile, many pioneering communities are already taking action to do exactly that. These communities have built coalitions to address their priority health challenges such as tobacco use in public spaces; educational attainment and economic opportunity; community safety; substance use disorders and mental health conditions; healthy built environment; and hazardous exposures in and around their homes and neighborhoods.

These innovative, multi-sector approaches to health reflect an understanding of the conditions and factors that are associated with health. Scholars estimate that behavioral patterns, environmental exposure, and social circumstances account for as much as 60% of premature deaths.[11] These factors shape the contexts of how people make choices every day—and reflect the social and physical environments where these choices are made. Driven by policy incentives toward population health, our health care system is transforming from a system focused on episodic, non-integrated care toward one that is value-

Figure 2 | Geography of Life Expectancy in the Bottom Income Quartile



Source: The Health Inequality Project. https://healthinequality.org

based and increasingly community integrated.[12] There are tremendous opportunities for the health care and public health systems to be better integrated in order to produce substantial and lasting health for individuals, communities, and populations.[13] The CDC developed a framework to conceptualize such integration spanning three "buckets" of prevention—traditional clinical preventive interventions, interventions that extend care outside the care setting, and total population or community-wide interventions to achieve the most promising results for population health (Figure 3. The Three Buckets of Prevention).[14] Regarding to the second and the third "buckets", CDC recently launched the Health Impact in 5 Years (HI-5) initiative, highlighting non-clinical, community-wide approaches addressing context factors or social determinants of health that have shown positive health impacts within five years and evidence of cost effectiveness or cost savings. These resources showed that community-wide actions addressing upstream determinants are not only evidence-based and feasible, but also of good value.

However, public health and social services have been immensely underfunded. Compared to its spending on health care, the United States has made lower investments toward upstream, non-medical determinants of health—social services such as income support, education, transportation, interpersonal violence and trauma, controlling hazardous environmental exposure and housing programs—and this has had detrimental effects on health.[15] States that spent more on social services and public health, relative to

Figure 3 | The Three Buckets of Prevention

Source: Auerbach, John. "The 3 buckets of prevention." Journal of Public Health Management and Practice 22.3 (2016):215-218

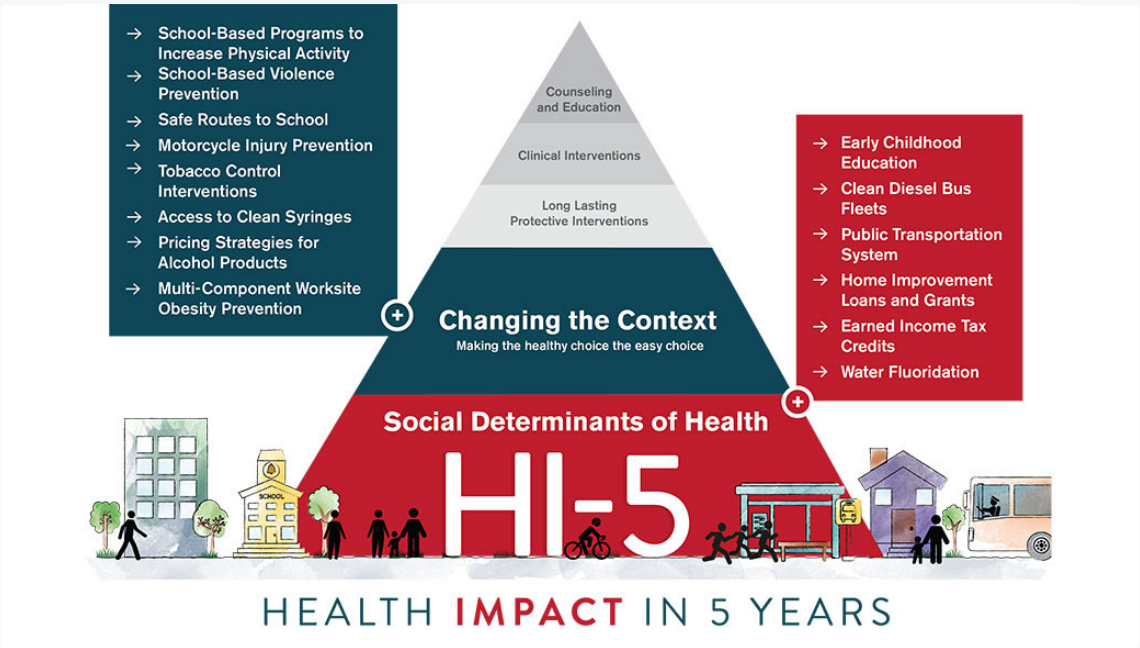
spending on medical care, had significantly better subsequent health outcomes.[16,17] Unfortunately, the 2008 recession precipitated a large and sustained reduction in state and local spending on public health activities.[18] Nearly two-thirds of the U.S. population in 2012 lived in jurisdictions in which their local health department reported budget-related cuts to at least one critical program area.[19]

The 2002 Institute of Medicine (IOM) report *The Future of the Public's Health in the 21st Century*[20] called for strengthening governmental public health capabilities and requiring accountability from and among all sectors of the public health system. The need to strengthen the public health system, however, is often only revealed in the context of disasters and crises. For example, in the aftermath of Hurricane Katrina in the City of New Orleans, it became apparent that restoring health care services alone was insufficient in restoring New Orleans' health system. For a community to address fundamental drivers of health while establishing readiness and resilience to crises, it requires strong public health infrastructure, effective leadership, usable data, and adequate funding. The water crisis in Flint, Michigan,[21] painfully reminded us of the costly consequences when environmental determinants of public health are not at the center of decision-making that impacts the health and safety of the public.

It is clear that to improve the health of all Americans, we must address factors outside of health care. Doing so means we must build upon past successes in public health and continue to attend to those issues, but also expeditiously work in a multi-sector fashion to get closer to the true definition of public health:

> **Public health is what we do together as a society to ensure the conditions in which everyone can be healthy.[22]**

Figure 4 | Health Impact in 5 Years



Source: U.S. Centers for Disease Control and Prevention, Health Impact in Five Years. http://www.cdc.gov/hi5

Public Health 3.0: A Renewed Approach to Public Health

To meet these new challenges, state and local public health entities have been innovating in partnership with their local communities a new model of public health. In this approach, pioneering local communities are building upon their historic success at health improvement, and adding a focus on social and environmental determinants of health to achieve health equity. They do this through deliberate collaboration across sectors, especially with non-traditional partners, and through assuming the role of Chief Health Strategist in their communities.

This expanded mission of public health—to ensure the conditions in which everyone can be healthy—was underscored in the IOM report *The Future of Public Health*[23] nearly two decades ago, and it remains salient today. Pioneering communities across the country are demonstrating how this can be achieved, particularly with local governmental public health in the lead or playing a prominent role. **We call this enhanced scope of practice Public Health 3.0.**

This evolved model of public health builds upon the extraordinary successes of our past. **Public Health 1.0** refers to the period from the late 19th century through much of the 20th century, when modern public health became an essential governmental function with specialized federal, state, local, and tribal public health agencies. During this period, public health systematized sanitation, improved food and water safety, expanded our understanding of diseases, developed powerful new prevention and treatment tools such as vaccines and antibiotics, and expanded capability in areas

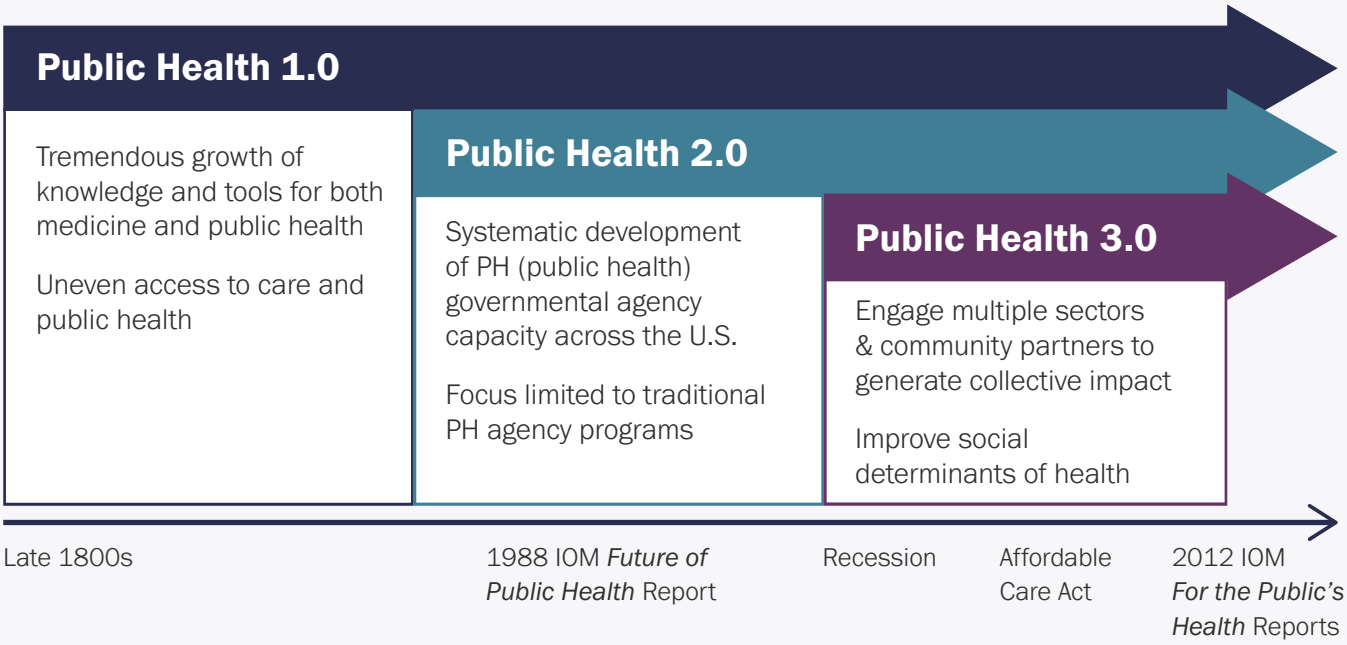
such as epidemiology and laboratory science. This scientific and organizational progress meant that comprehensive public health protection—from effective primary prevention through science-based medical treatment and tertiary prevention—was possible for the general population.

Public Health 2.0 emerged in the second half of the 20th century and was heavily shaped by the 1988 IOM report *The Future of Public Health*.[24] In that seminal report, the IOM described the many challenges faced by the American public health system. The report posited that public health authorities were encumbered by the demands of providing safety-net clinical care and unprepared to address the rising burden of chronic diseases and new threats such as the HIV/AIDS epidemic. The report's authors declared, "This nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."

With this call to action, the field of public health defined a common set of goals and core functions, and developed and implemented target capacities and performance standards for governmental public health agencies at every level. During the 2.0 era, governmental public health agencies became increasingly professionalized and standardized.

Public Health 3.0 refers to a new era of enhanced and broadened public health practice that goes beyond traditional public department functions and programs. Cross-sector collaboration is inherent to the PH3.0 vision, and the Chief Health Strategist role requires high-achieving health entities with the skills and capabilities to drive such collective action.[25] Only through inter-organizational

Figure 5 | Evolution of Public Health Practices



Source: DeSalvo et. al. (2016) Public Health 3.0: Time for an Upgrade. AJPH

There are five critical dimensions in the enhanced scope of public health practice:

Strong leadership and workforce

Strategic partnerships

Flexible and sustainable funding

Timely and locally relevant data, metrics, and analytics

Foundational infrastructure

cooperation can policy and systems-level actions be taken to affect upstream determinants of health. Several pioneering U.S. communities are already experimenting with this expansive approach to public health, and several national efforts are also supporting this new approach.[26]

Despite successes by many innovative local jurisdictions, these pioneering PH3.0 efforts face challenges in advancing and sustaining their work. At present, they have not had a shared, defining vision or framework. Many have developed in relative isolation, without opportunity to share best practices and lessons learned. There is not a central repository of tool kits or information to support their work. Finally, key elements needed to support their efforts such as flexible funding and access to timely data are not readily or systematically available.

Current and future public health leaders will need to embrace the Chief Health Strategist role in their communities, collaborating with stakeholders who can positively affect social determinants of health. In many communities the local health officer will serve the role of Chief Health Strategist, but this may not necessarily always be the case—indeed Chief Health Strategists can come from other sectors. Developing strong strategic partnerships with players in other sectors is paramount to the success of this approach. PH3.0 will need both new sources of funding and flexible funding mechanisms to support its cross-sector, social determinants–oriented work. To guide community efforts, current, geographically specific, and granular data will be needed, as well as practical, readily accessible tools for data analysis and an enhanced informatics workforce capacity. Finally, a strengthened public health infrastructure needs to be designed and institutionalized, so that cross-sectoral collaborative efforts survive changes in public health, community, and political leadership.

This report describes examples of PH3.0 based on a series of regional meetings held by OASH across the United States.

Chief Health Strategist

...will lead their community's health promotion efforts in partnership with health care clinicians and leaders in widely diverse sectors, and be deeply engaged in addressing the causes underlying tomorrow's health imperatives. The emphasis will be on catalyzing and taking actions that improve community well-being, and playing a vital role in promoting the reorientation of the health system towards prevention and wellness.

Chief health strategists will participate in and support community-based coalitions that examine health data, set goals, and develop plans to improve health. They will enlist civic and other community leaders such as key local businesses and the Chamber of Commerce as well as leaders at the grassroots level to help carry out those plans.

Source: Public Health Leadership Forum, The High Achieving Health Department in 2020 as the Community Chief Health Strategist, 2015. http://www.resolv.org/site-healthleadershipforum/hd2020/

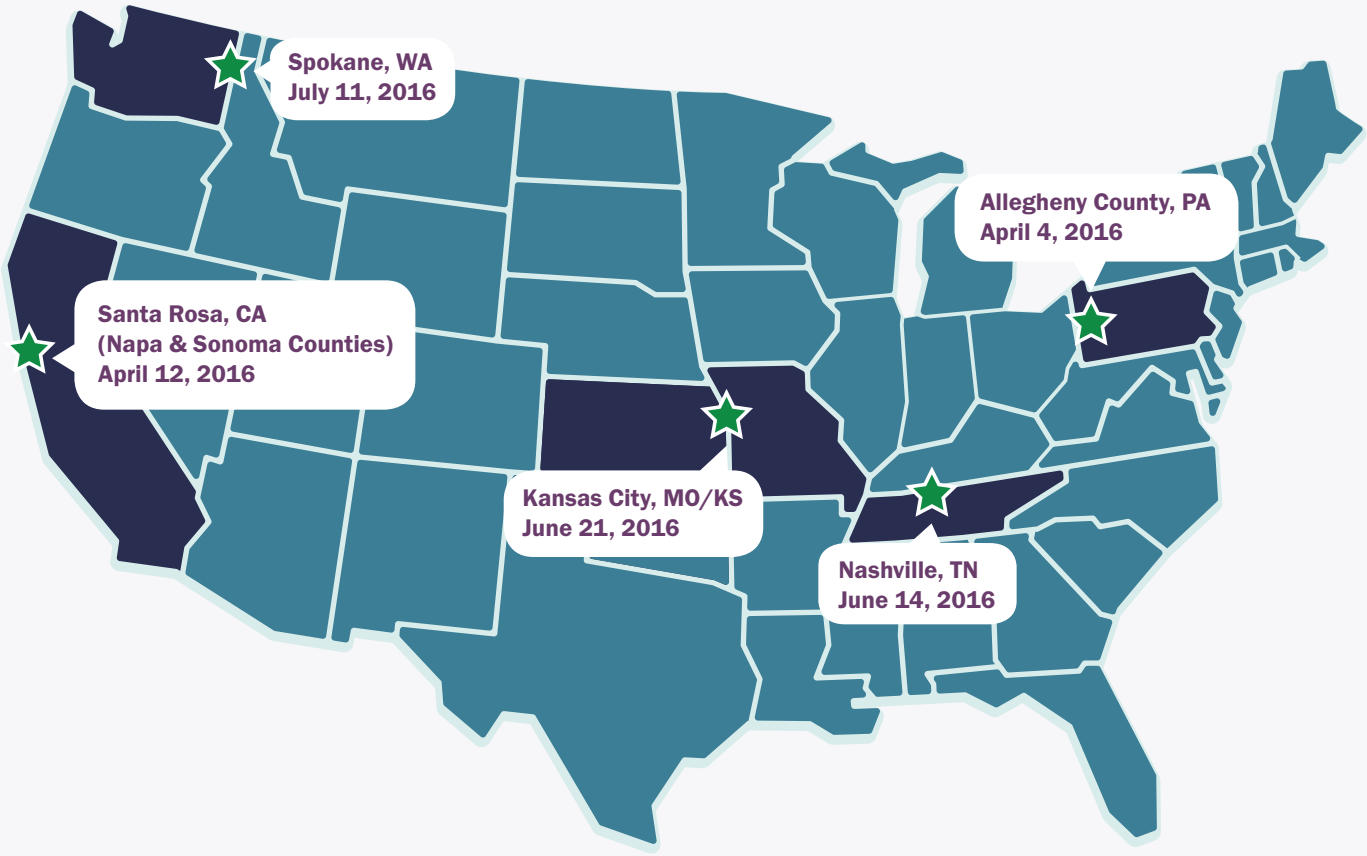
The National Dialogue

At the core of PH3.0 is the notion that local communities will lead the charge of taking public health to the next level and ensuring its continued success and relevance. In 2016, OASH engaged with stakeholders across a variety of sectors—state and local public health (including the Association for State and Territorial Public Health Officials [ASTHO] and the National Association of City and County Health Officials [NACCHO]), philanthropic and nonprofit groups, businesses, social service organizations, academia, the medical community, state and local government agencies, transportation, environmental services, and others. OASH also engaged directly with state and local health officers, both those who had seen success in innovative, outside-the-box approaches to implementing public health practice and those who had experienced challenges.

Spotlight and Feedback: Public Health 3.0 Regional Meetings

Many communities across the U.S. are taking innovative approaches to public health and have developed cross-sector, collaborative structures to address the social, environmental, and economic determinants of health. Over spring and summer 2016, OASH leadership visited five of these geographically and demographically diverse communities.

Figure 6 | Five communities across the U.S. that are taking innovative approaches to public health.



The purpose of the regional meetings was three-fold:

1. For local leaders to share their knowledge, strategies, and ideas for moving PH3.0-style work forward
2. To hear about the successes and challenges for each of the five PH3.0 domains not only from host communities, but also from others in the region
3. To gather information about how the broader public health system could support local governmental public health as it transformed into a PH3.0 model

Meeting participants represented a wide array of expertise beyond public health and health care. While the majority of participants were from the local communities, we welcomed people and organizations from across the regions. Though participants noted unique challenges and successes, many common themes emerged across the meetings. These key findings are summarized below.

Key Findings: Strong Leadership and Workforce

PH3.0 relies on not only a strong, diverse, and policy-oriented public health workforce, but also leaders who can work in new ways to build structured coalitions, leverage actionable data and evidence, and communicate new approaches

within and outside of the traditional health sector. Meeting participants discussed several strategies for developing new public health leaders and for inspiring the existing public health workforce to transform the public health system in their communities.

1. Building a strong public health workforce pipeline.

Participants noted the challenges in finding sufficient incoming talent and the high turnover rates in local public health. They suggested innovative approaches, enhanced partnerships, and new incentives to attract and retain talent. Academic institutions can establish mentorship programs, expand internships to include non-traditional opportunities, or work with federally funded job training programs. Opportunities also exist within primary education; some participants also suggested integrating public health into science, technology, engineering, and mathematics (STEM) curricula.

> “Public health is now more central to all the health sciences disciplines than ever before.”
>
> *— Participant, Spokane*

For public health professionals already in the workforce, new benefits or incentives (both financial and non-financial) may encourage them to stay in the field. Public health entities should create opportunities for growth within their organizations and celebrate individual successes.

2. Leading for collective impact.[27]

Strategic cross-sector partnerships drive PH3.0-style efforts, but the skills necessary to form and cultivate these partnerships may be foreign to public health practitioners who have long operated in silos. Existing opportunities for developing collaboration, leadership, and other essential skills should be explored. This can serve as a means to both grow expertise in the public health field and involve local stakeholders in achieving collective impact. In addition, public health and partners in other sectors can identify opportunities for exchanging skills and cross-pollinate their professional development activities. To build in-house capacity, participants suggested that public health entities also consider providing formal online training and certification opportunities.

> “With PH3.0, our existing leaders need to shift, to step out of the box of their own personality and be able to serve the team, serve the connections.”
>
> *— Participant, Santa Rosa*

3. Thinking outside of the box.

Several participants noted the importance for public health leaders to think creatively in order to seize critical opportunities for growth. Forward-thinking businesses may serve as models for PH3.0. For example, the incubator system popularized by the technology industry allows established businesses to provide management training to help startup companies succeed. Similarly, participants suggested recruiting people who have skills, training, or education that are not traditional to the public health

Bright Spot of Innovation: *Live Well Allegheny*

In January 2014, Allegheny County Executive Rich Fitzgerald launched *Live Well Allegheny*, a response to county residents who expressed a desire to develop a healthier lifestyle.

The *Live Well Allegheny* campaign aims to improve the health and well-being of people in Allegheny County by addressing behaviors that lead to chronic diseases. The initiative, now led by the Board of Health and Allegheny Health Department Director Karen Hacker, asks county residents to increase physical activity, decrease cigarette smoking, and take a proactive role in managing their own health. Ultimately, the campaign will also incorporate efforts to improve mental wellness, personal and community safety, preparedness, quality of life, education, and health literacy.

Live Well Allegheny brings together local stakeholders across Allegheny County, including municipalities, school districts, government agencies, community-based organizations, academia, and the private sector, to improve the community's health. It includes programs such as *Live Well Communities*, Live Well Schools, *Live Well Restaurants*, and *Live Well Workplaces*. To achieve *Live Well* status, each community or entity must demonstrate its commitment to achieving campaign goals.

To date, *Live Well Allegheny* has:

1. 22 *Live Well* communities
2. 5 *Live Well* school districts (with more in progress)
3. 10 *Live Well* restaurants
4. 1 *Live Well* workplace
5. 112 partners committed to *Live Well*

For more information, read the 2014–2015 Live Well Allegheny Biannual Report.

field. Community advocates and organizers, for example, embody many qualities that could support PH3.0-style efforts: authentic community voices, relationships with community members, enthusiasm for effecting change, and the ability to grow a grassroots movement. Business and entrepreneurial experience represent another example. In addition, by forging partnerships with non-traditional collaborators like universities and business mentorship programs, health departments can expand their capacity and their skill sets.

Key Findings: Strategic Partnerships

Participants identified building blocks for successful strategic partnerships across sectors, including key partnership attributes, strategies for engaging partners, and partners critical to PH3.0-style initiatives.

1. Establishing backbone entities for strategic planning and funding.

Participants noted that a politically neutral backbone entity is an essential component of any successful collaborative effort. The entity would convene and collect input from partners, mobilize funding, and drive action toward shared goals. Participants noted that backbone entities are most effective when they have political and social capital, including the public's trust and respect.

Participants warned against the pitfall of unstructured collaboratives in which group members only engage in discussion without committing to formal working partnerships. The backbone organization requires structure, including timelines, work plans, and most importantly, concrete mechanisms to pool and deploy funding and other resources.

> "It doesn't matter who you get into a room, if you don't have a doer, it will be a lot of ideas but not how you accomplish them. . . If people in the room don't have the power to implement, it's just going to be a lot of talk."
>
> *— Participant, Nashville*

2. Cultivating new and existing relationships.

Participants noted that PH3.0-style initiatives hinge on authentic and strong relationships to yield sustained collaboration and impact, and should align the values of each participating organization's missions.

Developing trust and communication takes time—particularly when cultivating new relationships. Participants suggested that convening organizations invest this time strategically. They urged conveners not to overlook seemingly minor steps like meeting face to face, clearly explaining each partner's value, setting expectations for how each partner will contribute, and setting deadlines for meeting the group's goals.

> "This is relational work, we're all people. It never hurts to take a one-off meeting, meet face to face with people."
>
> *— Participant, Santa Rosa*

3. Identifying collective goals and defining value.

Participants noted that collaborations are successful when they bring together entities with diverse, relevant expertise. Conveners should also consider non-traditional partners, who can often add important value and insight. At times, crises serve as opportunities to catalyze partnerships and stimulate collaborative efforts by producing a collective goal to resolve a pressing community challenge; that collective goal can inspire and drive collective action.

Bright Spot of Innovation: *Healthy Kansas City*

In 2014, more than 100 local stakeholders came together to identify ways for the business community to become active leaders in health. That initial strategy session led to Healthy KC, a partnership of the Greater Kansas City Chamber of Commerce, Blue Cross Blue Shield of Kansas City, and other regional health organizations. The collaborative aims to create a culture of health in Greater Kansas City.

Healthy KC selects interventions based on local issues and community needs. In the Kansas City region, tobacco use among youth is a significant problem: nearly 25% of high school students in Missouri and Kansas are current tobacco users. In response, Healthy KC launched the Tobacco 21|KC initiative, an offshoot of a national effort to increase the minimum age for the sale and purchase of tobacco products from 18 to 21. Healthy KC initially set a goal for five communities to adopt Tobacco21 ordinances by 2018, and they have vastly exceeded that goal: as of June 2016, 15 municipalities had jumped on board. Tobacco21 ordinances now cover 1.2 million people and have resulted in 1,000 fewer smokers each year.

Healthy KC credits effective partnerships with making Tobacco 21|KC a success. Because local stakeholders—including the public health community, school districts, businesses, and chambers of commerce—have embraced and advocated for the initiative, city councils have been more willing to adopt these ordinances. The business industry has a vested interest in reducing tobacco use since each employee who smokes costs employers an average of more than $6,000.

Healthy KC has also developed initiatives to promote mental health, workplace wellness, healthy eating, and active living.

Participants noted the importance of identifying the value a potential partner adds to the group, in addition to defining the expected return on investment for the partner. Several participants recommended proactively answering the question, "What's in it for me?" For example, one participant described how Sonoma County successfully engaged the business community in health care workforce development. Since the decrease in skilled workers is a key concern of the business community, the group was able to define the value proposition of growing the local pipeline for skilled health care professionals.

Participants identified other specific sectors that have not traditionally worked with public health but

are relevant to PH3.0-style collaboratives. These include but are not limited to:

- Behavioral health agencies
- Chamber of commerce and/or individual business owners or developers
- Community- and faith-based organizations
- Early care and education
- Elected officials and legislators
- Employers
- Funders
- Housing
- Human services
- Labor unions
- Media and marketing professionals
- Public safety and law enforcement
- Schools and departments of education
- Substance use disorder treatment programs
- Third-party payers
- Transportation
- Tribal entities

One participant noted that a critical partner may also be "the person you never thought to ask." This can be a helpful reminder to think creatively about goals and who else has a stake in achieving them.

> "Partnerships don't evolve on their own—they take time, effort, commitment, and a common goal."
>
> *— Participant, Kansas City*

Key Findings: Flexible and Sustainable Funding

Funding enables groups to implement the programs, training, or infrastructure changes necessary to achieve a collective goal. However, local initiatives perpetually struggle to secure sufficient funding and resources, and many funding sources are categorical or disease specific. Strategies for leveraging sustainable and flexible funding that support PH3.0-style work were discussed.

1. Leveraging shared goals.

Participants suggested that the backbone entity should identify funders whose missions resonate with those of the initiative while cautioning against changing the mission or goal to fit a funding source. As with any partnership, developing and sustaining connections with funders takes time. In some cases, funders invested in an initiative may have over time become active partners.

> "We need flexible and smarter funding for shared goals. We need to identify shared goals on the front end so we don't head down parallel paths without conversation in between."
>
> *— Participant, Spokane*

Participants urged conveners to consider unconventional partners, such as venture capital firms committed to social change, and non-monetary resources, like access and influence. Backbone entities can also identify opportunities to re-allocate funds from existing public health

programs or capitalize on successful community projects already underway. By piggybacking on existing efforts, collaboratives can pool resources with partners working toward the same or different goal.[28] For example, a food waste rescue effort could meet the mission of hunger relief as well as reduce food waste.

2. Breaking funding silos.

Historically, public sectors have had access to distinct, narrowly defined federal, state, and local government funding streams. Before PH3.0, this approach was seen as effective: public health departments organized their service by conditions (e.g., HIV/AIDS, maternal and child health, diabetes), and funding streams supported that style of work. But this model tends to fall short when addressing social determinants of health or building capacity for readiness. A move from categorical, siloed funding to more flexible funding models also allows local leaders to respond more rapidly to emerging community needs.

Participants noted that the public health system should advocate for flexible spending dollars by stressing the efficiency in avoiding duplicated work. Communities may also pursue removing barriers to pooling funding across organizations and jurisdictions, which would enable programs to mix funds for collective efforts.

Participants noted that funder engagement is critical to sustaining funding. Collaboratives can, for example, leverage program evaluation results to show impact, and to collect and share data. In particular, capturing and documenting cost savings attributable to the initiative can be instrumental when seeking additional or continued funding; but data and analytic challenges exist.

3. Exploring alternative financing models.

Health care delivery system reform has catalyzed a shift from fee-for-service to pay-for-performance models. Several funding mechanisms, including Medicaid, now have ways to pay for population health outcomes. For financing public health, participants discussed the potential for pay-for-performance models and ones that blend and braid funding from public and private sources. One much-discussed example is the social impact bond model, where private funders invest in programs designed to yield a social impact and are repaid if and when the programs achieve desired outcomes.

Participants shared several suggestions for leveraging existing federal funding to advance population health, such as integrating prevention into Medicare Advantage. At the state level, the Medicaid Section 1115 waiver mechanism provides one potential funding source for transforming the payment and delivery system to improve population health. States could strategically use these waivers to implement demonstration projects that reduce the costs of care and then capture and reinvest these savings.

> “The chasm between primary care and public health is not built into the reimbursement structure. We need payment reform, a fundamental shift in how we reimburse care. The millennials coming into primary care are excited about bridging the chasm, but we need to bridge the funding gap.”
>
> *– Participant, Santa Rosa*

Bright Spot of Innovation: California Accountable Communities for Health

California has embraced a new model for achieving health equity: accountable communities for health (ACH). An ACH is a multi-payer, multi-sector alliance of health care systems, providers, insurers, public health, community and social service organizations, schools, and other partners.

The California Endowment has identified criteria for a successful, sustainable ACH:

- Shared vision and goals
- Partnerships
- Leadership that spans many organizations and is pervasive throughout each organization
- A backbone organization that convenes and facilitates the group, and mobilizes funding
- Capacity to collect, analyze, and share data across sectors
- A wellness fund that serves as a vehicle for attracting and pooling resources
- A portfolio of interventions that addresses social determinants of health from many angles, including clinical and behavioral interventions, clinical-community linkages, community programs and resources, and public policy, systems, and environmental changes

> "The idea [behind ACHs] is that if we can save money in the health care system, we may be able to reinvest that funding in upstream prevention."
>
> *— Karen Smith, Director and State Public Health Officer, California Department of Public Health*

Sonoma County has worked to develop an ACH infrastructure, including data-sharing capabilities and a wellness fund. It has also built a financing framework that includes:

- Backbone funding (for facilitation, strategy development, and infrastructure needs)
- Pooled funding (for pilot testing programs including non-traditional funding methods and proof-of-concept work)
- Innovative loan funding (for scaling up programs and long-term investments)

In Napa County, the Live Healthy Napa County (LHNC) collaborative has made progress toward becoming an ACH. For example, with backbone support from the Napa County Health and Human Services Agency, LHNC has established a shared vision and goals and has nurtured partnerships. Under LHNC's leadership, Napa County has developed a portfolio of interventions to address social determinants of health for priority issues, like overweight and obesity.

Key Findings: Timely and Locally Relevant Data, Metrics, and Analytics

Participants in all meetings highlighted the importance of reliable, diverse, real-time data to drive public health decision making. They noted several data obstacles, catalogued critical data types, and shared strategies for building local capacity to access, analyze, and apply data.

1. Addressing current data gaps and access challenges.

Public health practice relies on timely data that are locally relevant. Despite progress made in the national- and state-level survey infrastructure and the wide adoption of interoperable electronic health records, local public health professionals continue to face challenges in obtaining access to critical data that can guide their actions and track impact. Participants noted the prevailing time lag in existing data systems. For instance, publicly available National Health and Nutrition Examination Survey data were often collected several years prior. Many participants urged substantial expansion of county- and sub-county-level data collection efforts to enable local efforts that are pertinent to the population they serve. Further, there needs be a cultural shift in public agencies across the federal, state, and local levels in striving to make more raw, de-identified data available to researchers and the community in a more timely fashion to accelerate the translation of evidence to action.

Ancillary Event: Data, Metrics, and Analytics Roundtable, March 22, 2016

On March 22, 2016, OASH convened more than 40 thought leaders representing government, academia, and the private sector in Washington, DC to discuss the role of data in advancing public health.

Data, metrics, and analytics tools are critical to effective public health practice. Many local health departments currently rely on national data that are years old, were collected from labor-intensive surveys, or are not granular enough to inform local efforts. Even when public professionals can access essential data, they may struggle to link them to other data sets or use them effectively.

The full-day meeting focused on state and local health departments' data-related challenges and opportunities—and how the federal government can help modernize the data and analytics infrastructure. The group was unanimous that cross-sector partnerships can bolster the local public health data that professionals rely on. Panelists also highlighted innovative public health data initiatives across the country.

Roundtable participants developed an initial set of recommendations to collect, access, and use relevant data to support PH3.0 initiatives. The full meeting summary can be downloaded at: https://www.healthypeople.gov/2020/tools-resources/public-health-3/resources.

There are also substantial barriers to data sharing. In addition to significant variability in file formats and metrics of measurement, there is widespread misunderstanding of the Health Insurance Portability and Accountability Act requirements and a lack of expertise and capacity at the local level to handle the legal processes involved in data-sharing agreements across agencies and entities. Tracking individuals or linking individuals across different data systems is oftentimes impossible in the absence of unique personal identifiers. Participants suggested the need for best practices in data sharing that create interoperability standards while protecting privacy.

> “Granularity matters. We need community-level data to identify places with specific needs.”
>
> *– Participant, Allegheny*

2. Exploring new types of data.

Data traditionally collected by local public health officials at times paint an incomplete picture of a community’s challenges and successes. Participants encouraged local leaders to explore alternative sources of data, including hospital and ambulatory care records, health insurance claims, and electronic health records. These data sources provide trends and patterns of health care utilization and admissions/discharges. They often contain sufficiently granular location information, and are made available with only a short lag time. Many communities, for example, are using this type of data for “hot spotting” areas with high health care needs that may benefit from comprehensive preventive efforts.

To better understand community needs, participants also suggested taking advantage of data across sectors, especially data on upstream challenges related to income, education, housing, crime, interpersonal violence and trauma, environmental hazards, transportation, and education. Sources of these data include programs such as the Supplemental Nutrition Assistance Program (SNAP), the Homeless Management Information System, the American Community Survey, and the National Committee on Vital and Health Statistics (NCVHS) report, *Environmental Scan of Existing Domains and Indicators to Inform Development of a New Measurement Framework for Assessing the Health and Vitality of Communities*. Public health practitioners can also use cross-sector data to evaluate collaborative initiatives—for example, one could evaluate whether an intervention that promotes wellness among school-age youth results in improvement in educational attainment or graduation rate.

> “We need data on social determinants, prevention, and return on investment. We have to marry health economics with public health prevention and get people to take a long—not short—look.”
>
> *– Participant, Spokane*

Bright Spot of Innovation: *Priority Spokane*

Priority Spokane serves as a catalyst for focused improvements in economic vitality, education, the environment, health, and community safety. The collaborative convenes diverse partners from across the county, including the Spokane Regional Health District, Spokane Public Schools, the City of Spokane, the Spokane Housing Authority, and Greater Spokane Incorporated. Priority Spokane also includes local and regional hospitals, universities, and foundations.

Identifying Public Health Priorities

According to Priority Spokane, public health priorities must affect a significant number of people in the community, affect various areas within the community, and be actionable. To address public health priorities, Priority Spokane analyzes data, develops and implements data-driven strategies, and evaluates progress.

In 2009, Priority Spokane analyzed graduation rates to identify educational attainment as a priority indicator. The collaborative conducted a study of 7,000 public school students over two years to understand when students were falling behind and dropping out. These findings pointed to three tipping points: low attendance, suspensions for disruptive behavior, and low course completion.

Taking Action

Equipped with these insights, Priority Spokane took action to create essential supports for students that would help them stay on track. For example, Priority Spokane advocated for new state laws that promote restorative rather than exclusionary discipline, developed a mentorship program with Gonzaga University, and worked with community partners to establish a community dashboard for monitoring progress. In five years, Spokane's graduation rate jumped from 60% to 80%.

In 2013, Priority Spokane again followed this process to work toward solving another countywide public health priority: mental health issues among school-age youth. Priority Spokane received a Culture of Health Prize from the Robert Wood Johnson Foundation in 2014, in recognition for its work advancing community health.

3. Supporting data sharing and analysis.

Barriers to sharing, analyzing, and interpreting data can impede local efforts to assess needs and evaluate programs. Participants noted that sharing and analyzing data across sectors is critical to achieving a person-centric and community-centric perspective. To incentivize data sharing, local leaders need to articulate how it can support a collective goal. For example, health departments aiming to address the issue of sedentary lifestyles within the community can use transportation and city planning data to inform their efforts. However, participants also suggested that governance is required to create a platform for exchanging data across sectors and institutionalize data-sharing capabilities.

> "Public health departments need access to whole-person data across multiple organizations and agencies—and the ability to analyze and take action."
>
> *— Participant, Kansas City*

Key Findings: Foundational Infrastructure

Participants from all meetings identified salient features of a PH3.0-capable local health department and shared ideas about how to make progress toward institutionalizing these features.

1. Creating a mission-based, collaborative infrastructure.

Participants underscored the importance of public health departments developing a clear mission and roadmap centered on community needs and involvement. Local health departments embracing PH3.0 should welcome community engagement both formally—for example, through community advisory boards—and informally. Community engagement means focusing not only on disseminating information to communities, but also on collecting information from communities.

According to participants, a PH3.0 public health department should reflect PH3.0 values—collaboration, equity, and commitment to addressing social determinants of health—in its mission statement, strategic plan, organizational chart, and new-hire orientations. State and local health departments should also include information technology and data capabilities (collecting, analyzing, disseminating, and acting on them) in their routine quality improvement process. In addition, participants noted that a PH3.0 health department is one whose financing mechanism allows for flexibility in its funding to respond to emerging health concerns.

2. Focusing on equity and cultural competence.

Participants explained that local and state health departments must adopt an equity lens through which they view the community and their work. Health departments can institutionalize this approach by training all staff in cultural competence. Participants suggested a few training options—for example, computer-based training on implicit (unconscious) bias—but also noted that

engaging with the community is the best training. Many agreed that making one person accountable for equity is not sufficient; rather, there has to be a department-wide cultural shift.

> "A PH3.0 infrastructure requires cultural humility and competency—a recognition that I don't know what I don't know."
>
> *— Participant, Nashville*

3. Articulating foundational infrastructure and the public health "brand."

Participants defined PH3.0 health departments of the future as forward-thinking change makers. Several urged HHS to continue to communicate a PH3.0 model that communities can tailor to fit local culture and priorities. Departments can take other steps to institutionalize PH3.0 operations and leadership, such as documenting processes for making decisions and taking collective action. Documentation helps to ensure the continuation of activities even as leaders come and go. Participants noted that the department's structure can also promote a PH3.0 ethos; for example, departments can build cross-disciplinary teams internally or create a horizontal leadership structure. In addition, they could develop a center, unit, or program housed within the department dedicated to external relations, strategic development, and community engagement.

To foster a cultural shift to PH3.0 within departments, participants from local public health departments shared the experience of undergoing accreditation as a significant process for assessing their capacity to deliver essential public health services, improve quality, and enhance their accountability. Participants also called on the private sector to engage, collaborate, and create shared value. Emulating private sector

Bright Spot of Innovation: *Nashville Health*

Nashville is a thriving city with a robust health care delivery system—but many residents suffer from poor health. NashvilleHealth is a new collaborative founded by Senator William Frist, MD, that adds momentum and dimension to the county's collective effort to improve health.

NashvilleHealth is guided by a simple mission: to substantially improve the health and well-being of Nashvillians.

In its first year, NashvilleHealth will focus on:

- Preventing and curbing tobacco use, since Tennessee has one of highest tobacco use rates in the nation (23%)
- Lowering high blood pressure rates, since high blood pressure can lead to several chronic health conditions
- Creating conditions in which children can be healthy, since behaviors adopted in childhood are predictors of wellness later in life

The collaborative will leverage resources and relationships to address these problems from several angles. To support this important work, NashvilleHealth is developing a framework for effecting change that is affordable, sustainable, and scalable.

NashvilleHealth aims to make Nashville one of the healthiest places to live in the state and the nation. The collaborative will use state and national health rankings to measure progress toward this goal—and will strive to make Nashville number 1.

business practices could take health departments a long way. These processes include implementing meaningful metrics, timelines, and deliverables. Participants also noted that certain skills that are traditionally thought of as valuable only in the private sector—such as sales and marketing—are useful in public health. The ability to approach a new partner, deliver a "sales" pitch, and forge new collaborative ventures is not only valuable—it is essential to PH3.0.

> "[PH3.0 health departments need] a culture of creativity and innovation: capable of storytelling, engagement practices, creative place making."
>
> *— Participant, Santa Rosa*

Recommendations to Achieve Public Health 3.0

The era of Public Health 3.0 is an exciting time of innovation. Without support from across the broader public health system, however, public health entities will not be able to achieve or sustain their transformation. Our recommendations reflect what we heard from the public health community across the country, from conversations with leaders, and from a review of prior reports that lay out a framework for strengthening public health. We propose five key recommendations that define the conditions needed to support health departments, and the broader public health system as it transforms.

We also propose specific actions that can be taken related to these broader recommendations.

1. Public health leaders should embrace the role of **Chief Health Strategist for their communities**—working with all relevant partners so that they can drive initiatives including those that explicitly address "upstream" social determinants of health. Specialized Public Health 3.0 training should be available for those preparing to enter or already within the public health workforce.

In many communities the local health officer will serve the role of Chief Health Strategist, but this may not necessarily always be the case—indeed Chief Health Strategists can come from other sectors. In the PH3.0 era, the public health workforce must acquire and strengthen its knowledge base, skills, and tools in order to meet the evolving challenges to population health, to be skilled at building strategic partnerships to bring about collective impact, to harness the power of new types of data, and to think and act in systems perspective. This will require a strong pipeline into the public health workforce, as well as access to ongoing training and mid-career professional development resources.

a. Public health associations such as ASTHO and NACCHO should develop best practice models and training for current public health leaders looking to work as Chief Health Strategists.

b. The Health Resources and Services Administration (HRSA) should incorporate principles of Public Health 3.0 and social determinants of health in their workforce training programs, including the National Health Service Corps orientation, public health training center, and National Coordinating Center for Medicare and Medicaid Services Accountable Health Communities Model.

c. Local public health agencies should partner with public health training centers and academic schools and programs of public health to inform training that meets the local public health workforce needs.

d. The business and public health communities should jointly explore leadership development and workforce enrichment opportunities such as short-term fellowships or exchange programs, with a particular focus on the financial and operational capacity of local health departments. Academic institutions should encourage their faculty and administrations to develop meaningful partnerships with local public health departments and support service learning and internships for students from all disciplines in state and local health departments.

e. Academic institutions should encourage their faculty and administrations to develop meaningful partnerships with local public health departments and support service learning and internships for students from all disciplines in state and local health departments.

f. Local health departments should train their leaders and staff in the concept and application of the collective impact model of social change.

g. Public health should work with leadership institutes and business schools to establish professional development resources and opportunities.

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2 Public health departments should engage with community stakeholders—from both the public and private sectors—to form vibrant, **structured, cross-sector partnerships** designed to develop and guide Public Health 3.0–style initiatives and to foster shared funding, services, governance, and collective action.

Communities should create innovative and sustained organizational structures that include agencies or organizations across multiple sectors but with a shared vision, which allows blending and braiding of funding sources, capturing savings for reinvestment over time, and a long-term roadmap for creating health, equity and resilience in communities. In some communities the local heath department will lead, but others may lead these efforts.

a. Local public health agencies should form cross-sector organizational structures aimed at achieving a collective vision of community health that are capable of receiving and sharing resources and governance.

b. HHS should work with others to develop a report defining the key characteristics of successful local public health models that address social determinants of health through cross-sector partnerships and recommending pathways to wide adoption.

c. The Assistant Secretary for Preparedness and Response (ASPR) and the CDC should work with state and local health entities to ensure synchronization between health care practices, coalitions, and public health entities. Pre-crisis collaboration is essential to improve sharing of limited resources, improve timely and accurate communication, and improve sharing of data relevant to preparedness planning and response.

d. Local public health leaders should engage with elected officials to create cross-jurisdictional organizational structures or partnerships for all community development efforts.

e. Public health entities should partner with environmental health agencies to address the environmental determinants of health.

f. HHS should continue to develop tools and resources (such as the HI-5) that identify system-level drivers of health disparities, connecting health and human services, and work with communities to translate evidence to action.

g. HRSA should recommend that health centers to document collaboration with their state and/or local health department.

h. Health care providers should identify clear mechanisms to engage with local public health as part of their effort to achieve the three-part aim of better care, smarter spending, and healthier people.

i. The Centers for Medicare and Medicaid Services (CMS) and ASPR should work together to ensure state and local public health entities engage health care providers during times of crisis or disaster. Preparedness measures are essential to healthier and more resilient people.

j. The Substance Abuse and Mental Health Services Administration should encourage state mental health and substance use disorder agencies and other grantees to collaborate with state, local, and tribal public health entities in achieving PH3.0 goals.

k. The Agency for Health care Research & Quality should ensure linkages between primary care and public health via the Primary Care Extension Program and evaluate outcomes.

l. The National Institutes of Health should continue its community participatory research and engagement efforts, such as the Clinical and Translational Science Awards and the Partnerships for Environmental Public Health, to accelerate translation of evidence to community action, as well as to generate new knowledge in the evaluation and implementation of public health interventions.

m. Public health leaders should pursue local partnerships to ensure population health is central in all community development efforts.

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3 Public Health Accreditation Board (PHAB) criteria and processes for department **accreditation should be enhanced** and supported so as to best foster Public Health 3.0 principles, as we strive to ensure that every person in the United States is served by nationally accredited health departments.

As of August 2016, 324 local, state, and tribal health departments have been accredited or in progress for accreditation, covering roughly 80% of the U.S. population. The vision of ensuring every community is protected by a local or a state health department (or both) accredited by PHAB requires major investment and political will to enhance existing infrastructure. While research found accreditation supports health departments in quality improvement and enhancing capacity, the health impact and return on investment of accreditation should be evaluated on an ongoing basis.

a. HHS should assess opportunities to incentivize PHAB accreditation through federal programs and policies.

b. HHS should require state and local health departments receiving federal grants to indicate their PHAB accreditation status, including applications in progress or plans to apply in the future.

c. The federal government should partner with the private sector to create a learning community for local health departments seeking to engage in PH3.0 work with a particular focus on collective impact models to address the social determinants of health.

d. Resources to support the accreditation process and maintenance should be more readily available from public and private funding sources.

e. PHAB should continue to evolve accreditation expectations by incorporating Public Health 3.0 concepts.

f. Philanthropic organizations supporting local public health activities and social interventions should require grant applicants to collaborate with local health departments.

g. ASTHO and NACCHO should accelerate their support of state and local health departments moving to accreditation.

h. PHAB and its strategic partners should continue to enable pathways to accreditation for small and rural health departments.

i. States should assess the efficiency and effectiveness of their local health departments, including addressing jurisdictional overlaps and exploring opportunities for shared services mechanisms.

4 Timely, reliable, granular-level (i.e., sub-county), and **actionable data** should be made accessible to communities throughout the country, and clear **metrics** to document success in public health practice should be developed in order to guide, focus, and assess the impact of prevention initiatives, including those targeting the social determinants of health and enhancing equity.

The public and private sectors should work together to enable more real-time and geographically granular data to be shared, linked, and synthesized to inform action while protecting data security and individual privacy. This includes developing a core set of metrics that encompasses health care and public health, particularly the social determinants of health, environmental outcomes, and health disparities.

a. HHS should utilize opportunities such as Healthy People 2030, NCVHS's population health subcommittee, the Evidence-Based Policymaking Commission, and the census to elevate metrics related to social determinants to be leading health indicators, to define community-level indicators that address the social determinants of health, and to explore models to leverage administrative data.

b. NCVHS should advise the secretary of HHS to incentivize the integration of public health and clinical information.

c. CDC should continue its work with the private sector to make sub-county-level data including health, health

care, human services, environmental exposure, and social determinants of health available, accessible, and usable.

d. HHS should work with public health leadership and the private sector to develop a non-proprietary tool to support geographic information systems and other analytic methods for front-line public health providers.

e. Health systems and other electronic health data repositories should prioritize data sharing at the federal, state, and local level with the goal of achieving a learning health system inclusive of public health by 2024 as described in the Office of the National Coordinator for Health Information Technology (ONC) Nationwide Interoperability Roadmap.

f. The HHS Office for Civil Rights should continue to develop guidance for the public health system to provide clarity on private and secure data use, as well as guidance to promote civil rights compliance to address those social determinants which are the product of discriminatory practices.

g. ONC and the Administration for Children and Families should continue to establish clear data and interoperability standards for data linkage between health and human services sectors.

h. HHS should continue to identify gaps in the collection of data relating to race/ethnicity, language, gender identity or sexual orientation in existing surveys. When feasible, governmental and nongovernmental stakeholders at all levels—federal, state, local, and tribal—should collect standardized, reliable data concerning disparities.

i. HHS should facilitate linking environmental and human services data to health.

5 **Funding for public health should be enhanced and substantially modified,** and innovative funding models should be explored so as to expand financial support for Public Health 3.0–style leadership and prevention initiatives. Blending and braiding of funds from multiple sources should be encouraged and allowed, including the recapturing and reinvesting of generated revenue. Funding should be identified to support core infrastructure as well as community-level work to address the social determinants of health.

To secure sufficient and flexible funding in a constrained and increasingly tightening funding environment, local public health needs a concrete definition of the minimum capabilities, the costs of delivering these services, and a structured review of funding streams to prioritize mandatory services and infrastructure building.

a. The CMS and private payers should continue to explore efforts to support population-level health improvements that address the social determinants of health.

b. HHS should explore transformation grants for state and local health departments to evolve toward PH3.0 structure, analogous to the State Innovation Model (SIM) grants to support health care system transformation.

c. State governments receiving funds through SIM or Medicaid Waiver processes should be required to document their health department accreditation status, and their strategies for addressing the social determinants in partnership with their local public health departments.

d. States should maximize their use of the funding through the Health Services Initiative option under the Children's Health Insurance Program to advance their public health priorities for low-income children.

e. HHS should enhance its coordination both within the department and with other agencies, developing and executing cross-agency efforts to strategically align policies and programs that address the social determinants of health.

f. Public and private funders should explore options to provide more flexibility for accredited health departments to allocate funds toward cross-sector efforts including partnership development and collective impact models in addressing the social determinants.

g. Communities should examine how to best use the ACA's community benefits requirement for nonprofit hospitals by coordinating the alignment of the data collection process and pooling resources, and how these can be used to advance and provide funding for public health.

h. Public health agencies and academic institutions should periodically calculate the funding gap—the difference between the costs of providing foundational capabilities by each local health department and its current funding level—and communicate these figures in the context of forging partnerships and expanding funding sources.

Conclusion

The Public Health 3.0 framework leverages multi-sector collaboration to address the non-medical care and social determinants in communities, with local public health entities at the core, serving as Chief Health Strategists in their communities.

This sort of cooperation across the broader health system will be necessary to assure health equity for everyone, regardless of race/ethnicity, gender identity or sexual orientation, zip code, or income. At the local level, this effort will require a Chief Health Strategist, and local public health is best suited to serve in that role. For local public health leaders and entities to step up to this challenge, they will need to build upon their past successes and transform their agencies.

The exciting news is that many public health leaders and communities across the United States are doing just that. They are forging a new framework for public health that is leveraging new partnerships and resources to create the conditions in which everyone can be healthy. To ensure that these innovative PH3.0-style health agencies and communities can sustain their work and spread the model to other communities, all parts of the public health system will need to not only invest appropriately in public health, but support its ongoing transformation. Only then, through the collective actions of our society, can we ensure the conditions in which everyone can be healthy. The time is now to create the robust public health infrastructure needed to improve the public's health; the time is now for Public Health 3.0.

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Endnotes

[1] Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States. July 26, 2010. Available from: http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm

[2] Kochanek KD, Murphy SL, Xu JQ, Tejada-Vera B. Deaths: Final data for 2014. National vital statistics reports; vol 65 no 4. Hyattsville, MD: National Center for Health Statistics. 2016. http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf

[3] U.S. Department of Health and Social Services. (n.d.). The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Retrieved from http://www.surgeongeneral.gov/library/reports/50-years-of-progress/fact-sheet.html

[4] Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2015 http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf

[5] National Academy of Medicine. (2013). *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington, DC: National Academies Press.

[6] Life expectancy at birth and at age 65 remained the same in 2012, 2013, and 2014. Murphy, S. L., Kochanek, K. D., Xu, J., & Arias, E. (2015). Mortality in the United States, 2014. *NCHS Data Brief 229*. http://www.cdc.gov/nchs/data/databriefs/db229.pdf. Kochanek, K. D., Murphy, S. L., Xu, J., & Arias, E. (2014). Mortality in the United States, 2013. *NCHS Data Brief 178*. http://www.cdc.gov/nchs/data/databriefs/db178.pdf

[7] National Center for Health Statistics, Centers for Disease Control and Prevention, eds. *Health, United States, 2015, with special feature on Racial and Ethnic Health Disparities*. Hyattsville, MD, 2016.

[8] Whitehead, LaToria. "The road towards environmental justice from a multifaceted lens." *Journal of environmental health* 77.6 (2015): 106-109.

[9] Institute for Health Metrics and Evaluation. (n.d.). U.S. Health Map. Retrieved from http://www.healthdata.org/data-visualization/us-health-map

[10] Resources for evidence-based interventions to address community health and safety issues are available from such sources as The Guide to Community Preventive Services.

[11] McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The Case For More Active Policy Attention To Health Promotion. *Health Affairs 21*(2), 78–93.

[12] Halfon, N., et al. (2014). Applying a 3.0 transformation framework to guide large-scale health system reform. *Health Affairs 33*(11), 2003–2011.

[13] Institute of Medicine. (2012). *Primary Care and Public Health: Exploring Integration to Improve Population Health*. Washington, DC: The National Academies Press.

[14] Auerbach, J. (2016). The 3 buckets of prevention. *Journal of Public Health Management and Practice 22*(3), 215–218.

[15] Bradley, E. H., et al. (2011). Health and social services expenditures: associations with health outcomes. *BMJ Quality & Safety 20*(10), 826–831.

[16] Rogan, E., & Bradley, E. (2016). Investing in Social Services for States' Health: *Identifying and Overcoming the Barriers*. New York: Milbank Memorial Fund.

[17] Bradley, E. H., et al. (2016). Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09. *Health Affairs 35*(5), 760–768.

[18] Mays, G., & Hogg, R. (2015). Economic shocks and public health protections in US metropolitan areas. *American Journal of Public Health 105*(S2), S280–S287.

[19] National Association of County and City Health Officials. (2012). Local health department job losses and program cuts: findings from the January 2012 survey. Retrieved from http://www.naccho.org/topics/infrastructure/lhdbudget/upload/research-brief-final.pdf

[20] Institute of Medicine. (2002). *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.

[21] Frist, B., & DeSalvo, K. (2016). What The Flint Water Crisis Reveals About Public Health. *Forbes*. Retrieved from http://www.forbes.com/sites/billfrist/2016/02/11/what-the-flint-water-crisis-reveals-about-public-health/

[22] Institute of Medicine. (1988). *The Future of Public Health*. Washington, DC: The National Academies Press. doi:10.17226/1091

[23] Institute of Medicine. (1988). *The Future of Public Health*. Washington, DC: The National Academies Press. doi:10.17226/1091

[24] Institute of Medicine. (1988). *The Future of Public Health*. Washington, DC: The National Academies Press. doi:10.17226/1091

[25] RESOLVE. (n.d.) The High Achieving Health Department in 2020 as the Community Chief Health Strategist. Retrieved from http://www.resolv.org/site-healthleadershipforum/hd2020/

[26] Koo, D., O'Carroll, P., Harris, A., & DeSalvo, K. (2016). An Environmental Scan of Recent Initiatives Incorporating Social Determinants in Public Health. *Preventing Chronic Disease 13*.

[27] Kania, John, and Mark Kramer. "Collective impact." (2011): 36-41.

[28] Robinson, T. N. (2010). Save the world, prevent obesity: piggybacking on existing social and ideological movements. *Obesity 18*(S1), S17–S22.

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