Metropolitan Board of Health of Nashville and Davidson County
November 1, 2019 Retreat Minutes

The retreat meeting of the Metropolitan Board of Health of Nashville and Davidson County was called to order by Chair Alex Jahangir at 1:00 p.m. in the Board Room, on the third floor of the Lentz Public Health Center, 2500 Charlotte Avenue, Nashville TN 37209.

Present

Alex Jahangir, MD, MMHC, FACS, Chair
Tené H. Franklin, MS, Vice-Chair
Thomas Campbell, MD, member
Carol Etherington, RN, MSN, FAAN, member
David A. Frederick, MS, member
Margreete Johnston, MD, MPH, member
Sanmi Areola, PhD, Interim Director of Health
Tom Sharp, Policy Director and Governmental Liaison
Alex Dickerson, JD, Metropolitan Department of Law

Welcome

Chair Jahangir welcomed everyone and distributed a copy of an article regarding the Nashville Community Health+Well-being Survey (Attachment I) and a copy of the Centers for Disease Control Preventing Chronic Disease article "Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century" (Attachment II).

NALBOH Update

Vice Chair Franklin shared information she received at the National Association of Local Boards of Health's Annual Conference, which she attended in August 2019 (Attachment III).

Process for Selection of New Director

Chair Jahangir gave a brief description of how the most recent process for hiring a new director had been conducted, and led discussion on how to determine a process to be followed during the current search, including how to identify and incorporate feedback from internal and external stakeholders, Board participation in candidate selection, how to develop questions for candidates, methods of interviewing candidates, potential committees, and timeline.

Board members were asked to send their suggestions for panel members to Dr. Areola.

Charter Amendment Suggestions

Tom Sharp presented the Department's proposed amendments to the Metro Charter. Board members suggested revisions and asked that an updated draft be presented at the November 14, 2019 regular Board meeting for further discussion.

Conversation Regarding Board Interaction with Staff

Dr. Areola and Alex Dickerson explained that Board members' interactions with staff should be limited to learning the work of the Department, and that interactions beyond that scope could interfere with members' ability to hear appeals as members of the Department's Civil Service Board.

Conversation Regarding Board Priorities and Desires

Chair Jahangir asked each Board member to share their interest in public health as well as their motivations and inspirations for serving as members of the Board of Health.

Other Business

Dr. Areola advised he would provide an Equity Report as well as a list of the Department's priorities and an overview of what is expected in 2020.

Alex Dickerson advised that he would provide an update to the Open Meetings Law presentation at the regular Board meeting on November 14.

Dr. Areola invited the Board to join him and the ELT on Wednesday, November 27, for Tennessee Department of Health Commissioner Lisa Piercey's visit to the Department.

Dr. Areola advised that Rhonda Graham would provide administrative support to the Board beginning in January 2020. Ms. Graham gave a brief recounting of her career at the Department.

The meeting was adjourned at approximately 5:00 p.m.

Respectfully submitted,

A. Alex Jahangir, MD, MMHC, FACS
Chair

NASHVILLE COMMUNITY
Health + Well-being Survey

Survey Findings Offer Critical Insights into Nashville's Health

In the first countywide health assessment in nearly 20 years, the 2019 *Nashville Community Health and Well-being Survey* provides an up-to-date picture of the health of our city.

Survey findings show bright spots, as well as some inequities and areas for improvement. While most Nashvillians have health insurance and a primary care physician, too many still struggle to manage hypertension, obesity and mental health challenges-- with wide demographic, economic and geographic disparities across our community.

Since these survey findings include a broad range of indicators for the health status and behaviors of adults in Davidson County, as well as their access to and utilization of health-care resources, this comprehensive data will also establish a foundational baseline to inform and enhance the important health-related work already underway by government agencies, non-profits, businesses and other organizations in the community to create a culture of health.

Key Findings:

Vast Majority of Nashvillians Have Health Insurance and Visit their Doctor Annually
Two-thirds of all adults in Davidson County (67.5%) report having a personal doctor or health care provider. A similar proportion (64.7%) indicated they had visited a physician for a routine check-up within the past year. The vast majority (90.1%) of Nashvillians reported currently having health insurance coverage.

- While the majority of African Americans (79.7%), Whites (61.6%), and Mixed Races (56.7%) received a check-up from a doctor in the past year, less than half (46.1%) of the Hispanic/Latino population received a check-up in that time period.
- The Hispanic, and Lesbian, Gay, and Bi-sexual populations were less likely to be insured (67% of Hispanics/ 70% of Lesbian, Gay, and Bi-sexual population reported having insurance coverage).
- Those Nashvillians who are uninsured reported significant barriers to seeing a physician during the past year.
    - 60% of the uninsured face cost-related barriers to obtaining care.
    - 54.6% did not take prescription medications due to cost.

Obesity is a Challenge for the City
Based on self-reported weight and height, which was used to calculate Body Mass Index scores, an alarming two-thirds of all adults in Davidson County (63.6%) are considered obese or overweight.

- Unlike other health indicators within the survey, overweight and obesity rates remained high among all Nashvillians regardless of education and income levels.
- The Northwest Zone of Davidson County saw the highest levels of obesity with 72.5% of its residents classified as either overweight or obese.
- Large racial disparities exist: 78% of African American respondents, 73% of Hispanic/Latino respondents compared to 55% of White respondents are classified as overweight or obese.
- Nashvillians self-reported only consuming 3 servings of dark green vegetables and 5 servings of fruit during the past *week*. (The USDA's Dietary Guidelines recommend adults eat at least 5 and up to 13 servings of fruits and vegetables each *day*.)

Too Many Nashvillians Struggle with Poor Mental Health

Davidson County residents reported having 5.3 poor mental health days involving stress, depression, and problems with emotions in a 30-day period. This outpaces the state average (4.5 days), and those of similar sized peer cities Austin (3.3 days) and Charlotte (3.4 days) and the national average (3.8 days).

- Women self-reported 6.2 poor mental health days each month compared to 4.3 for men.
- About one-in-five adults (22.1%) indicated having been diagnosed with a depressive disorder, and 15.5% of Nashvillians report currently taking medicine or receiving treatment from a doctor or other health professional for a mental health condition or emotional problem.

Tobacco Rates Differ Across County— Vaping Leads Among Young Adults

13.2% of Nashvillians report they are current smokers and 6.6% of respondents said they were current users of e-cigarettes or vaping products. Among the 18-29 demographic, more people reported vaping (13.7%) than smoking (12.2%).

- In Nashville's East Zone, the smoking rate is double the city average (26.3%). The East Zone was also the area of the community most likely to suffer from respiratory illnesses like COPD, emphysema, chronic bronchitis, and asthma (26%).

Social Determinants Influence Health and Well-being in Nashville

The health and wellness divide in Nashville largely tracks along income levels and educational attainment.

- *Hypertension* - Almost one-third of all Davidson County adults (30.5%) have at some point been diagnosed with hypertension, also known as high blood pressure, by a doctor, nurse or other health care professional.
    - But those rates jump even higher for Nashvillians who never graduated high school (39.6%). College-educated Nashvillians saw much lower hypertension rates (17.7%) than the city-wide average.
- *Mental Health* - Nashvillians with lower levels of educational attainment and lower incomes also have more self-reported poor mental health days than their higher income and more educated neighbors.
    - Those who never graduated high school self-reported more than 10 poor mental health days each month, while those with a graduate or professional degree reported an average of 3.4 poor mental health days.
- *Opioid Use* - Education levels and income attainment are strongly associated with Nashvillian's use of painkillers and tranquilizers within the last year that were *not prescribed* by a doctor.
    - Those in households earning less than $25,000 a year were 12 times more likely than those making $100,000 or more a year to use opioids not prescribed to them within the past year.
    - Nashvillians with college degrees were less likely to take opioids not prescribed to them (3.8%), compared to those who had never graduated high school (11.8%).
    - Unemployed Nashvillians were twice as likely to use prescription pain relievers or tranquilizers (8.2%) that were not prescribed to them compared to employed Nashvillians (4.4%).
- *Tobacco Use* - The highest prevalence of every day cigarette smokers (23.6%) is found among those who never graduated from high school and from those whose households earn less than $25,000 annually (15.3%). In comparison, only 1% of Nashvillians with graduate degrees and those with higher household incomes smoke cigarettes every day.

ABOUT THE SURVEY:

NashvilleHealth and the Metro Public Health Department (MPHD) partnered with the University of Illinois at Chicago Survey Research Laboratory to field the *Nashville Community Health & Well-being Survey*. Available in English and Spanish, this first-of-a-kind large-scale assessment was mailed to over 12,000 Davidson County households and garnered a 15 percent response rate. A total of 1,805 respondents aged 18 and over answered either online or via a mailed paper questionnaire. The results are weighted to reflect the latest Census estimates for Davidson County and presented citywide and also broken down by gender, age, ethnicity, education, employment status, annual household income, health insurance coverage, sexual orientation, and geographic zones of Davidson County (East, Promise Zone, North West, South East, South West).

*Peer city data is sourced from the Robert Wood Johnson Foundation County Health Rankings

For a full copy of the *Nashville Community Health & Well-being Survey* results, please visit: https://www.nashville.gov/Health-Department/Data-and-Publications/Community-Health-Survey.aspx

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
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SPECIAL TOPIC

Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century

Karen B. DeSalvo, MD, MPH, MSc[1]; Y. Claire Wang, MD, ScD[2]; Andrea Harris, MSc[3]; John Auerbach, MBA[4]; Denise Koo, MD, MPH[5]; Patrick O'Carroll, MD, MPH[6]

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PEER REVIEWED

Editor's Note: This article is a joint publication initiative between *Preventing Chronic Disease* and *NAM Perspectives*.

Abstract

Public health is what we do together as a society to ensure the conditions in which everyone can be healthy. Although many sectors play key roles, governmental public health is an essential component. Recent stressors on public health are driving many local governments to pioneer a new Public Health 3.0 model in which leaders serve as Chief Health Strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity. In 2016, the US Department of Health and Human Services launched the Public Health 3.0 initiative and hosted listening sessions across the country. Local leaders and community members shared successes and provided insight on actions that would ensure a more supportive policy and resource environment to spread and scale this model. This article summarizes the key findings from those listening sessions and recommendations to achieve Public Health 3.0.

Introduction

The United States has made enormous progress during the past century in improving the health and longevity of its population through public health interventions and high-quality clinical care. In 2015, life expectancy at birth was 78.8 years, 10 years longer than in the 1950s (1). Smoking prevalence rates among adults and teenagers are less than half what they were 50 years ago (2). The proportion of people without health insurance is at a historic low of 8.8% (3). Health reform efforts have also improved health care quality and slowed the growth rate of health care costs.

However, this success falls short of ensuring that everyone in America can achieve an optimal and equitable level of health. The Centers for Disease Control and Prevention (CDC) recently reported that the historical gain in longevity in the United States has plateaued for 3 years in a row (4). Racial and ethnic disparities persist across many health outcomes and conditions, including life expectancy, infant mortality, and exposure to environmental pollutants (5). The gap in life expectancy between people with the highest and lowest incomes is narrow in some communities but wide in others (6). By mapping life expectancies in several cities across the United States, researchers illustrated that this metric can differ by as much as 20 years in neighborhoods just a few miles apart (7). These data suggest that investing in safe and healthy communities matters, especially for the most disadvantaged populations (8). However, many of these challenges require community-based interventions beyond health care. Indeed, today a person's zip code may be a stronger determinant of health than is his or her genetic code (7,9).

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. Education, safe environments, housing, transportation, economic development, access to healthy foods — these are the major social determinants of health, comprising the conditions in which people are born, live, work, and age (10). Fortunately, many pioneering communities across the country are already working to improve health by influencing these determinants in a positive way. From Nashville, Tennessee, to Manchester, New Hampshire, to Harris County, Texas, and the Shoalwater Bay Indian Tribe in Washington, community leaders

have built coalitions to improve educational attainment, promote economic opportunity, ensure community safety, and build environments that promote mental health and community engagement.

Key Influence of the Social Determinants of Health

Driven by payment policy changes, our health care system is transforming from one focused on episodic, nonintegrated care toward one that is value-based and would benefit from collaboration with allied community efforts. CDC developed a framework to conceptualize such integration across 3 areas of prevention—traditional clinical preventive interventions, interventions that extend care outside of the care setting, and population or community-wide interventions (11) (Figure 1). Although work in all of these areas is necessary to improve health, the work of Public Health 3.0 is focused on the second and third areas.

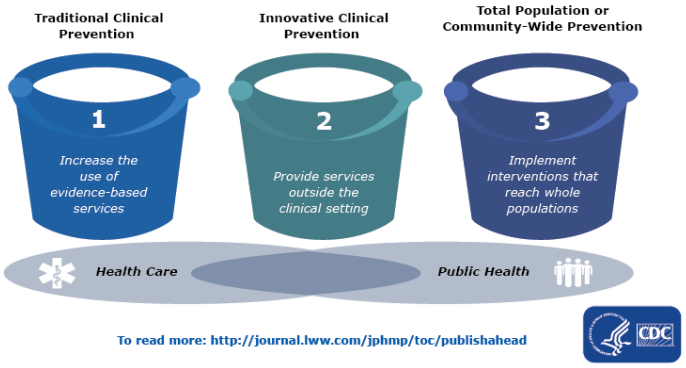

Figure 1. Centers for Disease Control and Prevention's Three Buckets of Prevention.

To improve the health of all people in America, we must also address factors *outside* of health care. Doing so means we must build on past successes and work across sectors to get closer to the essential definition of public health: *Public health is what we do as a society to ensure the conditions in which everyone can be healthy* (12).

The Evolution of Public Health

This expanded mission of public health was underscored in the 1988 Institute of Medicine (IOM, now the National Academy of Medicine) report, *The Future of Public Health* (12). It is even more salient today. Pioneering communities across the country are demonstrating how this can be achieved, particularly when led by local public health departments (13).

The 2002 IOM report, *The Future of the Public's Health in the 21st Century* (14), called for strengthening governmental public health capabilities and requiring accountability from and among all sectors of the public health system. However, public health has been significantly underfunded. Relative to health care spending, the United States has made paltry investments in upstream, nonmedical determinants of health, such as social services, education, transportation, environmental protection, and housing programs. This lack of investment has had detrimental effects on population health (15). In addition, the 2008 recession precipitated a large and sustained reduction in state and local spending on public health activities (16). In 2012, nearly two-thirds of the US population lived in jurisdictions in which their local health department reported budget-related cuts to at least one critical program area (17).

Unfortunately, the need to strengthen the public health system, and the peril for failing to do so, is often only revealed in the context of disasters and crises. For example, in the aftermath of Hurricane Katrina, it became apparent that restoring health care services alone was insufficient in restoring New Orleans's health care system. The water crisis in Flint, Michigan, reminded us of the costly consequences of not placing health and environmental impacts at the center when making decisions that affect the public's health. For a community to address fundamental drivers of health while establishing readiness and resilience to crises requires a strong public health infrastructure, effective leadership, useable data, and adequate funding.

Public Health 3.0: A Renewed Approach to Public Health

Public Health 3.0 builds on the extraordinary successes of our past (Figure 2). *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 prevention and treatment tools such as vaccines and antibiotics, and expanded capability in 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.

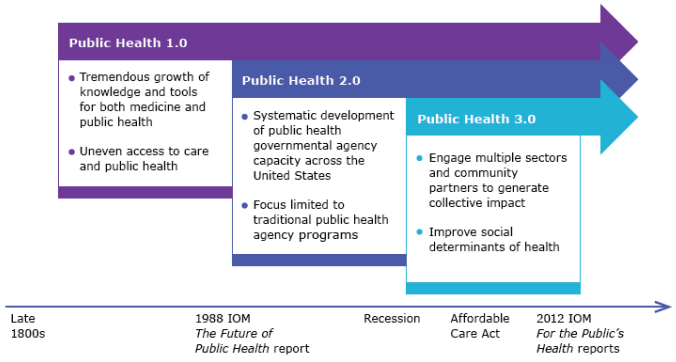

Figure 2. Evolution of public health practices. Abbreviation: IOM, Institute of Medicine.

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* (12). In that seminal report, the IOM posited that public health authorities were encumbered by the demands of providing safety-net clinical care and were 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 IOM defined a common set of core functions, and public health practitioners 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.

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-sectoral collaboration is inherent to the Public Health 3.0 vision, and the Chief Health Strategist role requires high-achieving health organizations with the skills and capabilities to drive such collective action. Pioneering US communities are already testing this approach to public health, with support from several national efforts.

Learning From the Field

At the core of Public Health 3.0 is the notion that local communities will lead the charge in taking public health to the next level and ensuring its continued success. Over the spring and summer of 2016, we visited communities across the United States to assess the accuracy of the 5 key components of the Public Health 3.0 framework and to hear firsthand what policy and other changes would support and sustain communities' Public Health 3.0 work.

We selected 5 geographically and demographically diverse communities and convened listening sessions with approximately 100 participants each. Each meeting showcased successful multisectoral collaboration designed to address the social determinants of health. The communities visited were Allegheny County, Pennsylvania; Santa Rosa, California; Kansas City, Missouri; Nashville, Tennessee; and Spokane, Washington. They were selected as representative of the broader Public Health 3.0 movement because of their national reputation for multisectoral collaboration, evidence of a strong local public health leader, innovative use of data and metrics, and funding. They also had experience in public health department accreditation. Allegheny County, Pennsylvania, is a prototype for the model including their work to form a structured partnership supporting health and blending and braiding funding across several governmental jurisdictions (18).

In these listening sessions, local leaders shared their knowledge, strategies, and ideas for successfully implementing Public Health 3.0–style initiatives. Meeting participants represented an array of expertise beyond public health and health care. Although participants noted unique challenges and successes in each region, many common themes emerged across the meetings.

Recommendations to Achieve Public Health 3.0

Based on insights gathered from the public health community at these listening sessions, from conversations with leaders, and from a review of prior reports that lay out a framework for strengthening public health, we propose 5 broad recommendations that define the conditions needed to support health departments and the broader public health system as it transforms into the Public Health 3.0 model. A more detailed list of specific actions can be found in the Appendix and in the full report (18).

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 the public health workforce and public health students.

Although the local health officer often may serve in the role of Chief Health Strategist, there are circumstances in which such leadership comes from those in other sectors. Regardless, the public health workforce must acquire and strengthen its knowledge base, skills, and tools 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 a systems perspective. This will require a strong pipeline into the public health workforce, as well as access to ongoing training and midcareer professional development resources.

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 and 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.

3. Public Health Accreditation Board (PHAB) criteria and processes for department **accreditation** should be enhanced and supported 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, approximately 80% of the US population lived in the jurisdiction of one of the 324 local, state, and tribal health departments that has been accredited or is in the process of becoming accredited by the PHAB (19). The vision of ensuring that every community is protected by an accredited local or a state health department (or both) requires major investment and political will to enhance existing infrastructure. Although research found accreditation supports health departments in quality improvement and enhancing capacity (20), the health impact and return on investment of accreditation should be evaluated on an ongoing basis.

4. Timely, reliable, granular-level (ie, subcounty), 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 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 encompass health care and public health, particularly the social determinants of health, environmental outcomes, and health disparities.

5. **Funding for public health should be enhanced and substantially modified**, and innovative funding models should be explored 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.

Early Action on the Recommendations

Upon the release of the report, several public and private organizations committed to advancing its recommendations. It was embraced by the American Public Health Association as the blueprint for the future of public health (21); others committed to developing training for Chief Health Strategists (22) or to building bridges between public health and the clinical care system, including payers (23). The US Department of Health and Human Services (HHS) implemented 3 priority recommendations, including extending reporting on accreditation status to federal public health entities, establishing a social determinants of health workgroup to support alignment of HHS policies, and launching a conversation about state-based opportunities to leverage health and human services resources to improve the public's health (23). Additionally, CDC's Health Impact in 5 Years (HI-5) initiative (24) provides nonclinical, community-wide toolkits to address social determinants of health that have demonstrated not only health improvement but also cost-effectiveness within 5 years. Community-level uptake and action through these resources could accelerate the impact of Public Health 3.0 collaborations.

Key Barriers

For many communities, transforming to a Public Health 3.0 model will prove challenging. Although funding has stabilized, local health departments continue to face resource challenges from local financing streams, and proposals to reduce federal public health spending are likely to have a major impact at the local level (25). Despite promising advances such as the Big Cities Project, the absence of nonproprietary tools for data, analytics, metrics, and other uses leaves actionable information out of reach for most localities (25). Additionally, the daily challenges of meeting statutory public health responsibilities and a lack of experience and skill

prevents most local health leaders from acting as Chief Health Strategists to bring people together across sectors. Finally, the basic foundational structure of local governmental public health may itself be a barrier to efficient and cost-effective coordination at the local level.

Conclusion

The era of Public Health 3.0 is an exciting time of innovation and transformation. With the Public Health 3.0 framework, we envision a strong local public health infrastructure in all communities and its leaders serving as Chief Health Strategists that partner with stakeholders across a multitude of sectors on the ground to address the social determinants of health. With equity and social determinants of health as guiding principles, every person and every organization can take shared accountability to ensure the conditions in which everyone can be healthy regardless of race, ethnicity, gender identity, sexual orientation, geography, or income level. If successful, such transformation can form the foundation from which we build an equitable health-promoting system — in which stable, safe, and thriving community is a norm rather than an aberration. The Public Health 3.0 initiative seeks to inspire transformative success stories such as those already witnessed in many pioneering communities across the country. The challenge now is to institutionalize this expanded approach to community-based public health practice and replicate these triumphs across all communities, for the health of all people.

Notes

We acknowledge the many communities and leaders who helped inform this work. The views expressed in this article are those of the authors and not necessarily of the authors' organizations, the National Academy of Medicine (NAM), or the National Academies of Sciences, Engineering, and Medicine (the National Academies). The article is intended to help inform and stimulate discussion. It is not a report of the NAM or the National Academies.

Author Information

Corresponding Author: Karen DeSalvo, MD, MPH, MSc, Former Acting Assistant Secretary of Health, US Department of Health and Human Services, 121 Rio Vista Ave, New Orleans, LA 70121. Telephone: 504-957-7094. Email: Karen.DeSalvo@gmail.com.

Author Affiliations: [1]New Orleans, Louisiana. [2]Columbia University, Mailman School of Public Health, New York, New York. [3]Washington, DC. [4]Trust for America's Health, Washington, DC. [5]Atlanta, Georgia. [6]The Task Force for Global Health, Decatur, Georgia.

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Appendix. Full List of Recommendations to Achieve Public Health 3.0.

Leadership & Workforce

- Public health associations such as Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NACCHO) should develop best practice models and training for current public health leaders looking to work as Chief Health Strategists.
- 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.
- 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.
- 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.
- Local health departments should train their leaders and staff in the concept and application of the collective impact model of social change.
- Public health should work with leadership institutes and business schools to establish professional development resources and opportunities.

Strategic Partnerships

- 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.
- The US Department of Health and Human Services (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.
- The Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (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.
- Local public health leaders should create cross-jurisdictional organizational structures or partnerships for community development efforts.
- Public health entities should partner with environmental health agencies to address the environmental determinants of health.
- HHS should continue to develop tools and resources (such as the HI-5 [Health Impact in 5 Years]) that identify system-level drivers of health disparities, connecting health and human services, and work with communities to translate evidence to action.
- HRSA should recommend that health centers document collaboration with their state and/or local health department.
- 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.
- 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.
- 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.
- The Agency for Healthcare Research & Quality should ensure linkages between primary care and public health via the Primary Care Extension Program and evaluate outcomes.
- 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.
- Public health leaders should pursue local partnerships to ensure population health is central in all community development efforts.

Infrastructure and Accreditation

- HHS should assess opportunities to incentivize Public Health Accreditation Board (PHAB) accreditation through federal programs and policies.
- 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.
- 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.
- Resources to support the accreditation process and maintenance should be more readily available from public and private funding sources.
- PHAB should continue to evolve accreditation expectations by incorporating Public Health 3.0 concepts.
- Philanthropic organizations supporting local public health activities and social interventions should require grant applicants to collaborate with local health departments.
- ASTHO and NACCHO should accelerate their support of state and local health departments moving to accreditation.
- PHAB and its strategic partners should continue to enable pathways to accreditation for small and rural health departments.
- States should assess the efficiency and effectiveness of their local health departments, including addressing jurisdictional overlaps and exploring opportunities for shared services mechanisms.

Data, Metrics, and Analytics

- 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.
- NCVHS should advise the secretary of HHS to incentivize the integration of public health and clinical information.
- CDC should continue its work with the private sector to make subcounty-level data including health, health care, human services, environmental exposure, and social determinants of health available, accessible, and useable.
- HHS should work with public health leadership and the private sector to develop a nonproprietary tool to support geographic information systems and other analytic methods for front-line public health providers.
- 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.
- 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.
- 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.
- 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.
- HHS should facilitate linking environmental and human services data to health.

Sustainable and Flexible Funding

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

- 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.
- 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.
- Communities should examine how to best use the Affordable Care Act'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.
- 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.

NALBOH
National Association of Local Boards of Health

Governance 101:

Intentional Governance for Local Boards of Health

Agenda

August 14, 2019

2pm – 5pm

2pm **Framework for Intentional Governance and Governance Best Practices**

- Twelve Characteristics of Intentional Governance
- Robert's Rules of Order for Small Boards
- Building Blocks for Intentional Governance

4pm **Special Topics for Boards of Health**

- Lobbying by Boards of Health
- Public Health 3.0: What is the role of the BOH?

4:50pm **Wrap-Up and Evaluation**

SAMPLE BOH Matrix Worksheet

Reviewed July 2019

This worksheet can be adapted by BOH to determine their ideal board composition, assess their current board composition and plan for the future by identifying individuals to fill in gaps. The Governance Committee can develop an appropriate grid for the organization and then present its recommendations to the full board.

In considering board building, the BOH and LHO is legally obligated to follow its bylaws, as well as laws and regulations which may include specific criteria on board size, structure and composition. An organization will look for different skills and strengths from its board members depending on circumstances facing the community, LHD or BOH or its strategic plan.

	IDEAL Composition	Current Members										Gaps	Prospective Members		
		1	2	3	4	5	6	7	8	9	10		A	B	C
Demographics															
Age															
Under 18															
19-34															
35-50															
51-65															
66+															
Gender															
Male															
Female															
Race/Ethnicity															
Black															
Asian															
White															
Hispanic															
Other Criteria															

	IDEAL Composition	Current Members										Gaps	Prospective Members		
		1	2	3	4	5	6	7	8	9	10		A	B	C
Areas of Expertise															
Small Business															
Financing	At least 1														
Planning	At least 1														
Economic Development															
Health Care															
Public Health	At least 1														
Health Insurance															
Social Services															
Philanthropy															
Primary Education															
Secondary Education															
Research/Academia															
Faith/Religion															
Government	At least 1														
Community Development															
Housing															
Transportation															
Extension															
Tourism															
Recreation															
Tourism															
Arts															
National Guard															
Veterans															
Media/Journalism															
Other:															
Geographic Area															
County?															
County?															
County?															
Number of years served on board:															

Sample Governance Policy

Reviewed July 2019

LHO **POLICY AND PROCEDURE GUIDELINES**	**Policy #: BOH- ###- ##**
SECTION: Board Policies	**Total Pages: 1 of 4**
SUBJECT: Board of Health: **Member Expectations**	**Effective Date: DRAFT** **Revised:** **Revised:** **Revised:**

The following code of conduct was adopted by the Board of Health (BOH) and sets forth the standards the board expects from its members.

Board purpose statement:

Our Board of Health's obligation is to ensure the Local Health Organization's (LHO) resources are deployed in ways that protect the health and improve the quality of life for all people in (name of county/service area). We carry out these responsibilities as described in (reference law, regulations, or other authorizing documents)

General Expectations:

1. Develop a working understanding of LHO's purpose, core values, vision, policies, programs, services, strengths and needs.

2. Assure that the health and health care needs of residents who live in our service area are represented in delivery of the **Ten Essential Services of Public Health**, which include:
    a. Monitor the health status of the community.
    b. Investigate and diagnose health problems and hazards.
    c. Inform and educate people regarding health issues.
    d. Mobilize partnerships to solve community problems.
    e. Support policies and plans to achieve health goals.
    f. Enforce laws and regulations to protect health and safety.
    g. Link people to needed personal health services.
    h. Ensure a skilled, competent public health workforce.
    i. Evaluate effectiveness, accessibility and quality of health services.
    j. Research and apply innovative solutions

3. Follow trends that impact LHO's areas of work.

4. Bring a sense of humor to the Board of Health's deliberations.

5. To become familiar with and committed to the three functions of our Board of Health:

    - **Policy development:** Develop policies that protect, promote, and improve public health while ensuring that the agency and its components remain consistent with the laws and rules (local, state, and federal) to which it is subject.

    - **Resource stewardship:** Assure the availability of adequate resources (legal, financial, human, technological, and material) to perform essential public health services.

    - **Legal authority:** Exercise legal authority as applicable by law and understand the roles, responsibilities, obligations, and functions of the governing body, health officer, and LHO staff. These may include, but are not limited to:

Fiduciary Responsibilities:

- **Duty of Care:** Requires that Board of Health members will be reasonably **informed** about the LHO's activities, **participate** in decisions, and do so in good faith and with care of an ordinarily **prudent person** in similar circumstances. The Duty of Care is carried out by the following acts:
    - To devote time to learn how the LHO functions, including its uniqueness, strengths, needs, and its place in the community and share your knowledge.
    - To carefully prepare for, regularly attend, and actively participate in board and committee meetings.
    - To willingly serve in leadership positions or undertake special assignments
    - To obtain the information needed to make good decisions
    - To maintain independence and objectivity and do what a sense of fairness, ethics, and personal integrity dictate.
    - To understand the role of the BOH as a policy-making body
    - To provide oversight while avoiding participation in management.

- To learn and consistently use designated organizational channels when conducting board business (e.g., responding to staff grievances, responding to inquiries concerning the status of a chief executive search, etc.)
- To periodically examine of the credentials and performance of those who serve the LHO.
- To ensure the quality of care and patient safety in the LHO
- To exercise reasonable business judgment in the conduct of board business.
- To actively participate in board discussions by asking critical questions and providing innovative resolutions to problems.

- **Duty of Loyalty:** Requires BOH members to exercise their power in the interest of the LHO and not in their own interest or the interest of another entity, particularly one in which they have a formal relationship. The Duty of Loyalty is carried out by the following acts:
  - To vote according to one's individual conviction, to challenge the judgment of others when necessary, yet to be willing to support the decision of the board and work with fellow board of health members in a spirit of cooperation.
  - To avoid the use of public opportunities for individual personal gain or benefit.
  - To make judgments always based on what is best for the LHO.
  - To serve the LHO as a whole, rather than special interest groups.
  - To comply with the conflict-of-interest and disclosure policy approved by the board.
  - To avoid accepting or offering favors or gifts from or to anyone who does business with the LHO
  - To maintain the confidential nature of board of health deliberations.
  - To avoid acting as spokesperson for the entire board of health unless specifically authorized to do so

- **Duty of Obedience:** Requires that Board of Health members comply with applicable federal, state and local laws, adhere to Board of Health's bylaws, and remain guardians of the mission. The Duty of Obedience is carried out by the following acts:
  - Compliance with all regulatory and reporting requirements.
  - Periodic examination of all governing documents and the Board of Health's operation.

- Making decisions that fall within the scope of LHO's mission and governing documents.
- Oversight of LHO's finances and programs and services
- Oversight of the quality of health care provided and patient safety when services are delivered by the LHO.

Ethos of Transparency: Although not a legal fiduciary duty, the Board of Health recognizes the importance of operating in a transparent manner, but not indiscriminately. Thus a culture of transparency requires that Board of Health members make that information available that ensures the public that the LHO is well managed, properly governed, financially secure and abides by ethical standards and values. We carry out this obligation by the following acts:

- Posting BOH minutes, after approval
- Posting on the LHO's website the Whistle Blower Policy.

The following information is considered private: (review given applicable laws and regulations)

- Planning documents
- Budget and financial statements;
- Minutes from Board of Health Executive Sessions
- Private addresses of board of health members and staff
- Personnel files
- Patient information

Meetings:

1. Regular Board of Health meetings are held (how often). Telephonic participation is permitted, but not encouraged to maintain positive group dynamics. (**Note:** electronic meetings must be allowed in bylaws).
2. It is anticipated that an annual board retreat will be conducted in most years as one of the board meetings.
3. Board committees meet most often by (state how and frequency of committee meetings, e.g. via conference call, face-to-face, on a schedule determined by committee members or set by the committee at the beginning of the year)

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Leadership for Improved Health

SAMPLE Annual BOH Calendar

APPROVAL DATE

NOTE: Sample assumes a July 1 – June 30th FY

Task	J	A	S	O	N	D	J	F	M	A	M	J
Executive Committee												
CEO/ED Performance Review												X
Finalize CEO/ED Performance Goals for Next FY												X
Add other tasks needed for year												
Board Development:												
Finance Committee												
Annual Audit						X						
Budget approval												X
Performance Plan Approval		X										
Review of Monthly Financial Statements and Financial Performance Indicators	X	X	X	X	X	X	X	X	X	X	X	X
Develop RFP for Audit (sample of a Finance Committee task that is not conducted every year)												
Review insurance coverages												X
Add other tasks needed for year												
Board Development:												
Performance Improvement Committee												
Annual Quality Improvement Plan approval by board												X
Review of QI Report & Performance Dashboard	X		X		X		X		X		X	
Add other tasks needed for year												
Board Development:												
Board Development:												
Governance Committee												
Annual Board Self-Assessment										X		
Board approval of Governance Structure and annual Work Plan												X
Review board matrix to identify needed skills/experience on board								X				
Officer Nominations												X
Annual Conflict of Interest and Confidentiality disclosure documents	X											
Add other tasks needed for year												
Board Development:												
Public Health 3.0												
Review of Community Health Improvement Plan Progress		X			X			X			X	
Identify cross-sector partners to engage in development/implementation of CHIP		X		X		X		X		X		X
Policy recommendations to create a Culture of Health in community/ies served												
Other Board Task Forces needed to conduct work during year e.g. Strategic Planning, Personnel Policy Review, Buiding, etc.												
List task to be completed												

XYZ Board of Health Sample Agenda

Date
Time
Location

- ➢ Decision needed
- • Information Item
- ○ Discussion Item

Business Issues — BOH Chair

- • Review of agenda
- ➢ Consent Agenda
  - CEO Report
  - Board minutes
  - Reports and other informational items
  - Could include BOH Committee minutes for information, not approval

Finance Committee Report — Treasurer/Finance Chair

- ➢ May 31, 2020 Financial Statements
- ➢ FY 2020 Budget
- ➢ Revisions to FIN-004-11: Purchasing Policy

Governance Committee Report — Committee Chair

- ➢ FY 2020 Officers
- ➢ FY 2020 Board Calendar and Governance Structure
- ➢ REVIEW Proposed bylaw revisions (Approval at next BOH meeting)
- ○ Board development/education needs for FY 2020

Performance Committee Report — Committee Chair

- ➢ DRAFT FY 2020 Quality Performance Measures
- ○ Discussion: Actions needed in follow up from Patient Satisfaction survey results

Community Health Committee Report — Committee Chair

- ➢ DRAFT FY 2020 CHNA
- ○ Discussion: How to engage businesses in community health improvement work?

REMINDERS:

- List upcoming meetings and other reminders

NOTE: **No staff reports on agenda, including CEO report, except under Consent Agenda; only reports reviewed are those needed to inform a decision today or at an upcoming BOH meeting**

Building Blocks for Intentional Governance

Fiduciary, Strategic and Generative Governance

Structures and Practices

Board Recruitment	Board Structure	Board Education & Development	Continuous Governance Improvement	Leadership Succession Planning
Organization's needs	Board size	Formal Orientation	Annual Evaluation of Board Performance	Written Policy Statement(s)
Board's needs	Zero-based Committee Structure	Ongoing Board Development	Annual Committee Assessment	Leadership Position Descriptions
	Board Member Term Limits			
Stakeholder Representation	Annual Board Work Plan	Resource Allocation	Individual Director Assessment /Peer Review	Development of Emerging Leaders
Board Diversity	Board Independence	Certification?	Peer Review Prior to Reappointment	
	Effective Meetings		Evaluate efficiency/ effectiveness beyond formal board assessment	
	Annual Board Calendar			
Statement of Board Member Expectations	Governing Documents		Cultural Assessment	

Board Culture

Empower people & give them freedom to act	Clear, strong and meaningful core values	Robust Engagement	Commitment to High Standards/ Performance	Transparency/ Accountability	Clear behavioral expectations	Constructive Partnership with CEO

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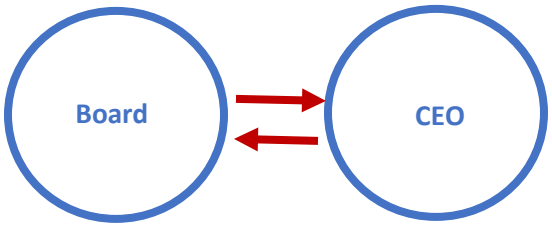
THE Center FOR Rural Health DEVELOPMENT
Leading the Way for Rural Health Issue

The Distinction between Management and Governance

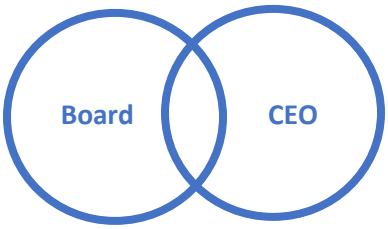
For Boards of Health

Reviewed July 2019

To bring value to the organization, board members need to have a clear sense of the fine line between management and governance. Although not absolute, there are differences between the two. Governance means setting policy and strategy. Management means implementing policy and strategy as set forth by the governing body.



Policy Governance



Governance as Leadership

In the Policy Governance model, there is an absolute distinction between the governance role of the board and the management role of the Executive Director (ED) or CEO. However, in reality this distinction is obscured by the complexity and dynamic nature of local public health organizations. Thus, in the Governance as Leadership model, the roles of the Board and ED are distinct with some overlapping responsibilities. There is not an absolute line between when leadership ends, and management begins, as both the Board and ED have leadership responsibilities. In addition, the Board has management responsibilities for reviewing the performance of the ED and providing feedback.

In the Governance as Leadership model, governance and management is a partnership endeavor. The future of the organization depends on the effectiveness of their mutual efforts. Nevertheless, it is the board of health that is ultimately responsible, legally and morally, for the local public health organization and all services it provides. Both the board and the ED must mutually support their respective roles for the organization to perform at the highest level.

The Board of Health should expect the following from its Executive Director and management team:

- A cooperative and open relationship — fully receptive to advice and counsel regarding the overall direction of the organization
- Guidance on policy and strategy development
- Sufficient amounts of the right kind of information, at the right time, to enable BOH members to collectively fulfill their duties
- Management's best interpretation of reports, performance indicators, etc., including implications
- An openness and receptivity to searching questions asked by BOH members
- Distribution to BOH members and/or it's committees of all communications by management to the Local Health Organization's various publics, including reports to funding sources, presentations to analysts, pertinent press releases, etc.

The Executive Director also has expectations of the BOH members:

- BOH members will be well prepared, having reviewed materials in advance, to discuss BOH or committee agenda items.
- BOH members will express their views on the quality, quantity, and timeliness of the information they receive from management in order for them to be prepared.
- BOH members will seek additional information when they need it; and delay making decisions based on partial information
- BOH members will exercise an active skepticism, articulate nagging doubts, and volunteer viewpoints.
- BOH members will be available to the chairperson and ED as needed for advice and counsel.
- BOH members will confine their activities to their role as board members, and not allow themselves to drift or be pulled into the management domain.

Cultural characteristics of a effective Boards of Health:

- BOH members do not act as policemen. They have a positive, optimistic view that the organization will succeed.
- Both the BOH and the ED equally exert influence and have input in creating value.
- The BOH focuses on unlocking its full potential to contribute by:
    - Being involved without micromanaging.
    - Challenging the ED but also being supportive.
    - Being patient but not complacent.
- The ED is secure in expecting that the BOH will be an open voice forum, a source of counsel, and a check on his/her own judgment
- The ED has the trust in the board so that he/she can:
    - Share information without feeling vulnerable.
    - Seek advice without appearing weak.
    - Solicit input without appearing to relinquish control over operational decisions.

Essentially, BOHs and EDs are accountable to each other and pursue the same goals for the local health department they serve, given their unique roles and responsibilities.

Use of Consent Agendas

Reviewed July 2019

A consent agenda is a parliamentary procedure that packages routine items together for board approval but NOT discussion. Items most often appropriate for the consent agenda include minutes, meeting dates, staff or operational reports, minutes from Board committees, and other routine business items.

The consent agenda avoids creating a "rubber stamp" board by allowing any board member to have an item removed from the consent agenda if he/she thinks it warrants discussion. **Use of a consent agenda requires that board committees are effective in conducting their work and that board members receive supporting materials well in advance of the meeting.**

What is a consent agenda?

A consent agenda is a component of a meeting agenda that enables the board to group routine items and resolutions under a single action item. As the name implies, there is a general agreement that issues in the consent package do not need any discussion before a vote. Unless a board member requests a removal of an item ahead of time, the entire package is voted on at once without any additional explanations or comments. Because no questions or comments are allowed on the consent package, time is saved during the meeting.

What items should be included in a consent agenda?

Routine, standard, non-controversial and self-explanatory are adjectives that will describe consent agenda items. *Each board should conduct a periodic discussion of items it wants to include on the consent agenda, as well as those items it does not want to include.*

How do we make a consent agenda function efficiently?

Board members are responsible for reviewing the items included on the consent agenda prior to the meeting. This requires that the information is distributed to board members well ahead of the meeting.

If a board member has a question, he/she should contact another board member or chief executive to clarify a concern prior to the meeting. If this is not helpful enough, during the meeting before a vote on the consent agenda, any board member may request that an item be removed from the consent agenda and discussed separately.

What cautions are there when using a consent agenda?

Although the use of consent agendas is becoming more common, there are still many people who are not familiar with this meeting procedure, thus the use of consent agendas needs to be well explained to all board members to ensure that everyone understands both the rationale and the steps involved. *To achieve the objective of a consent agenda – to save valuable discussion time for issues of consequence – it is important to make sure that board members receive support materials well before voting, and that they familiarize themselves with the details.*

When putting the agenda together, the board chair and the chief executive need to pay special attention to include only items that are suitable for routine processing. Board members need to be vigilant so that debatable issues do not accidentally pass through without appropriate deliberation.