A Public Health Workforce That Works

Staff shortages, a graying workforce, and changing job skills are driving regional planning for public health training.

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It's 2010, and public health professionals in the Northwest U.S. work in a supportive learning environment, with a constant supply of creative leaders and an extensive system for sharing and developing effective practices that ensure healthy communities.

In the 1990s the likelihood of implementing this vision of a sufficient supply of adequately prepared public health practitioners at times seemed grim. The infrastructure was hampered by unstable funding, staffing shortages, a graying cadre of workers, and inadequate technology. But the public health field is familiar with large, complicated health problems, and Northwest public health professionals have begun working together to apply their experience and creativity to generating the changes necessary to bring this vision into reality.

Lab session of a CDC bacteriology training class, 1963.

Public health practitioners have long excelled in the techniques of prevention: epidemiology, infectious disease control, immunizations, and others. Although these skills remain critical, our growing awareness of the complex determinants of health requires of public health more than technical expertise. Public health policy makers, practitioners, and academicians are focusing more and more on the effects on population health of such widely varying sectors as global trade, early childhood education, power generation, and local economic development. Public health professionals must be able to work with and within these other sectors if they have any hope of achieving the Institute of Medicine's stated goal of "creating the conditions in which people can be healthy." Moreover, demographic realities of American communities big and small in the 21st century demand that public health advocates be able to communicate and work in coalition with groups of diverse ethnic and religious backgrounds, involving agencies of multiple levels of government, and across rural-urban boundaries.

The training needs of the public health workforce have been the subject of intense discussion at the national level. Federal representatives, public health leaders, state and local practitioners, and many others have struggled to understand what competencies practitioners need in order to perform their jobs well in the face of the changing nature of public health work. The Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and some state health departments are committing more funds and resources to this effort every year.

Seeking a Coordinated Approach

Once additional competencies have been established, the next question is, how can public health practitioners be supported in developing and maintaining these competencies?

A variety of state and local groups have grappled with this question for some time. Universities, state health departments, and local providers have individually, and sometimes in partnership, made strides in providing professional development and support to the public health workforce. But this work has often been fragmented, categorical, discipline-specific, or geographically isolated.

Until now the Northwest has been the largest area of the United States with the least amount of coordinated workforce support. Recognizing the region's need for more support, in August 2000

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HRSA and CDC awarded grants to the Northwest Center for Public Health Practice at the University of Washington School of Public Health and Community Medicine to help coordinate a regional effort to improve public health practice through professional training and development.

Developing a Regional Approach

This coordinated regional effort moved beyond discussion and into action in January 2001 at a Seattle meeting of leaders in public health practice from the six Northwest states (Alaska, Idaho, Montana, Oregon, Washington, and Wyoming). Academicians and professionals from a variety of other disciplines also took part.

At the January meeting, 25 representatives from public health practice in local, state, tribal, urban, and rural settings shared their common concerns for improving the level of effective, ongoing support and appropriate training for those in public health practice. They immediately discovered that many of them suffered from the same workforce development barriers—rural isolation, travel limitations, lack of specific types of expertise, inadequately coordinated training efforts, overworked staff unable to leave work for professional development, and local and state government policies that do not satisfactorily support public health. They also recognized the value of sharing resources, trading workforce assessment tools, and discussing strategies for reducing these barriers to providing professional development support to their workforce.

Many of the participants reported that public health workers in their state and local health departments are retiring or leaving faster than new staff are being trained, vacancies filled, or future local leaders identified. At the same time, they increasingly have to hire staff from other employment sectors, who often lack a background in, or sufficient understanding of, basic public health concepts.

Salaries are generally low for people working in public health and particularly for those in rural settings, which makes it difficult to maintain an adequate workforce or to attract workers to rural communities.

The role of public health workers is also changing. As they work increasingly in partnership with other community agencies, for example, they need new and different skills, such as proficiency in facilitation and negotiation across agencies.

Snapshots: State Public Health Systems

Alaska

The state health agency is the Division of Health within the Department of Health and Human Services. The Section of Nursing supports 21 health centers, which serve more than 200 communities. Alaska has two local health departments: the North Slope Borough and the Anchorage Municipal Health Department. Some public health services, often personal health services, are provided by the Regional Native Health Corporations.

Idaho

Idaho has a regionalized, relatively autonomous local health department system. Primary health-related responsibility within the Idaho Department of Health and Welfare is delegated to the Division of Health. Autonomous local boards of health govern the seven multi-county district health departments.

Montana

Montana provides public health services through local and state public health agencies, tribal health and Indian Health Services, and privately funded organizations. The state has 52 local health departments within its 56 counties, of which 7 serve the major population centers. These local departments may or may not have local boards of health. They work closely with the State Department of Public Health and Human Services. Seven counties with no health departments contract with adjoining counties for public health services.

Oregon

The Oregon Health Division (OHD), within the Department of Human Services, provides resources, technical assistance, and consultation in a wide variety of areas, including medical, epidemiological, and technical and laboratory support. Local governments directly operate the 33 county public health departments and one multi-county health department, with or without a local board of health. In three counties, the local government contracts with private health clinics to perform public health clinical services, and one county has no health department.

Washington

The Washington State Department of Health is a cabinet-level agency that provides resources, technical assistance, and consultation in a wide variety of areas, including epidemiology, risk assessment, and technical and laboratory support. Washington also has a state Board of Health with specific statutory authority for some portions of the health code. The State Department of Health has authority for other portions. Washington has 34 local health jurisdictions providing front-line public health services within its 39 counties (county health departments, city-county health departments, and multi-county health districts). Local jurisdictions provide the bulk of direct services, though state programs retain direct service responsibility where some centralization makes sense. The state and local jurisdictions maintain an active partnership.

Wyoming

Wyoming's system is based on the individual counties, with many of the public health functions retained at the state level. The state health agency, the Division of Public Health, is a component of the State Department of Health. Wyoming has 23 local health districts, 21 of which are county units and 2 of which are city-county departments. All except the two largest are solely public health nursing offices.

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During the January meeting the participants also shared lessons they had learned in assessing the needs of their workforce and in delivering support. Pat Carr from the Alaska Department of Health and Human Services, for example, spoke of using their strong public health nursing sector to initiate a broader workforce development plan. Melanie Reynolds, of the Montana Department of Public Health and Human Services, described how the efforts in workforce assessment had identified a need for the 4 C's: Coordination, Changes, Curriculum, and Cash.

- Coordinate. How do we link?
- Changes. How do we manage changes in administration?
- Curriculum. How do we use available curricula, but make sure it's relevant for Montana?
- Cash. How do we develop sustainability?

Washington State Department of Health's Joan Brewster emphasized, "In our public health improvement efforts, we're looking at needs across the entire public health system, and everywhere we look, we're aware of workforce development implications."

Sample Activities in State Plans

Some of the initial plans being implemented and supported by state advisory groups for the first year of the Regional Network for Public Health Workforce Development include:

- Develop and implement a one-day workshop for the public health workforce, based on early findings of a newly conducted workforce assessment; follow this with a larger three- to five-day public health summer institute in summer 2002 (WY)
- Fund a half-time position to coordinate distance learning and other workforce development activities through the Montana Public Health Training Institute (MT)
- Support the delivery of supplementary instruction for a basic epidemiology course being delivered to public health practice staff (OR)
- Establish an annual conference opportunity for public health workers to participate in training activities that address gaps identified in assessment (ID)
- Inventory existing and accessible public health training/educational resources (AK)
- Fund additional staff time to support the Washington State Workforce Development Committee and its work, for example, in setting operational definitions for public health competencies and in supporting the development of related curricula (WA)

Although individuals and agencies in the region have many barriers and needs in common, each state has its own public health infrastructure, which of course affects the strategies and priorities it chooses for public health workforce development. (*See "Snapshots: State Public Health Systems" on p. 7 for brief descriptions of each state's system.*) Differing relationships with other local groups or organizations in each state, such as tribal governments and community organizations, have also influenced workforce development strategies. The states differ, too, in funding and academic resources and the strength and education level of disciplines within a state's public health workforce.

Balancing the Common and the Unique

At the January 2001 meeting, representatives from the six states formed the Northwest Regional Network for Public Health Workforce Development. With the facilitation and support of the Northwest Center, the Regional Network aims to capitalize on ways the states can share and coordinate resources. At the same time, the representatives recognized the need to give careful attention to situations, issues, and barriers specific to each state.

The objectives of the Regional Network include increasing accessibility to available workforce development resources, developing an infrastructure and plan for addressing gaps in existing opportunities, creating training curricula for and enhancing the use of distance-learning technology for the workforce, and evaluating the effects of the Network's collective activities on the public health workforce.

Since the January meeting, the Network has moved forward on implementing its objectives, and the Northwest Center has contracted with Network agencies to help support their workforce development plans. By the time the Network steering committee meets in June, the six states will all have completed public health workforce assessments, and the Center will have begun a regional analysis of these assessments.

Just as the six states are distinctly different from one another, they are also in different stages in their workforce development plans. Some, such as Washington and Montana, had completed public health workforce assessments in connection with previous statewide efforts. Idaho, on the other hand, has not had the opportunity to do such work and has benefited from the tools, technical assistance, and experi-

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ences of Network partners in conducting its recent assessment.

In each state existing or new advisory groups, facilitated by Network members, are charged with developing, implementing, and monitoring an effective workforce development plan that uses local and regional resources. (*See box on p. 8 for selected details from the state plans.*)

The Northwest Center has also provided technical support for these state activities, developed and facilitated communication systems among workforce development efforts across the region, convened groups participating in workforce development, monitored and participated in national workforce development task forces involved in or affecting the region, and developed resources to address regional workforce training gaps.

To meet some of the identified training gaps, the Northwest Center is developing curricula for regional use and state/local adaptation. Among the courses already under development are basic epidemiology, bioterrorism preparedness (*see p. 18 for an article on the bioterrorism training prototype*), "public health 101," management in a changing public health work environment, and community collaboration for public health. All the training modules being developed will have a distance-learning component.

Since previous workforce assessments, as well as the Regional Network, pointed at leadership development for public health workers as another regional workforce issue, the Center is also facilitating the development of a Northwest Public Health Leadership Institute. Three e-mail workgroups are researching models, target audience, marketing, and financing for the institute. The first Leadership Institute will be held in spring 2002.

Workforce development is much bigger than mere development and dissemination of public health training curricula. Efforts to address workforce issues offer an opportunity to strengthen public health infrastructure and communication. Improved systems that train, mentor, and develop peer support across the Northwest region will not only better prepare the current public health workforce, but will ensure stronger public health leaders for this region in the future. The coordinated efforts and relationships built through this expanding Network will ultimately bring into reality a regional environment that supports lifelong learning and a constant supply of new and creative public health leaders.

School children being immunized against diphtheria by public health doctor and nurses, Seattle, 1940.

Recommended Readings

American Journal of Public Health Aug 2000. This issue of the journal has several useful articles on workforce development.

Journal of Public Health Management and Practice May 1999. This issue focuses on workforce development.

Ferzoff RB, and Gebbie KM: The Public Health Work Force. In: *Public Health Administration; Principles for Population-Based Management*. Gaithersburg, MD: Aspen Publishers, 2001, pp 117-138.

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