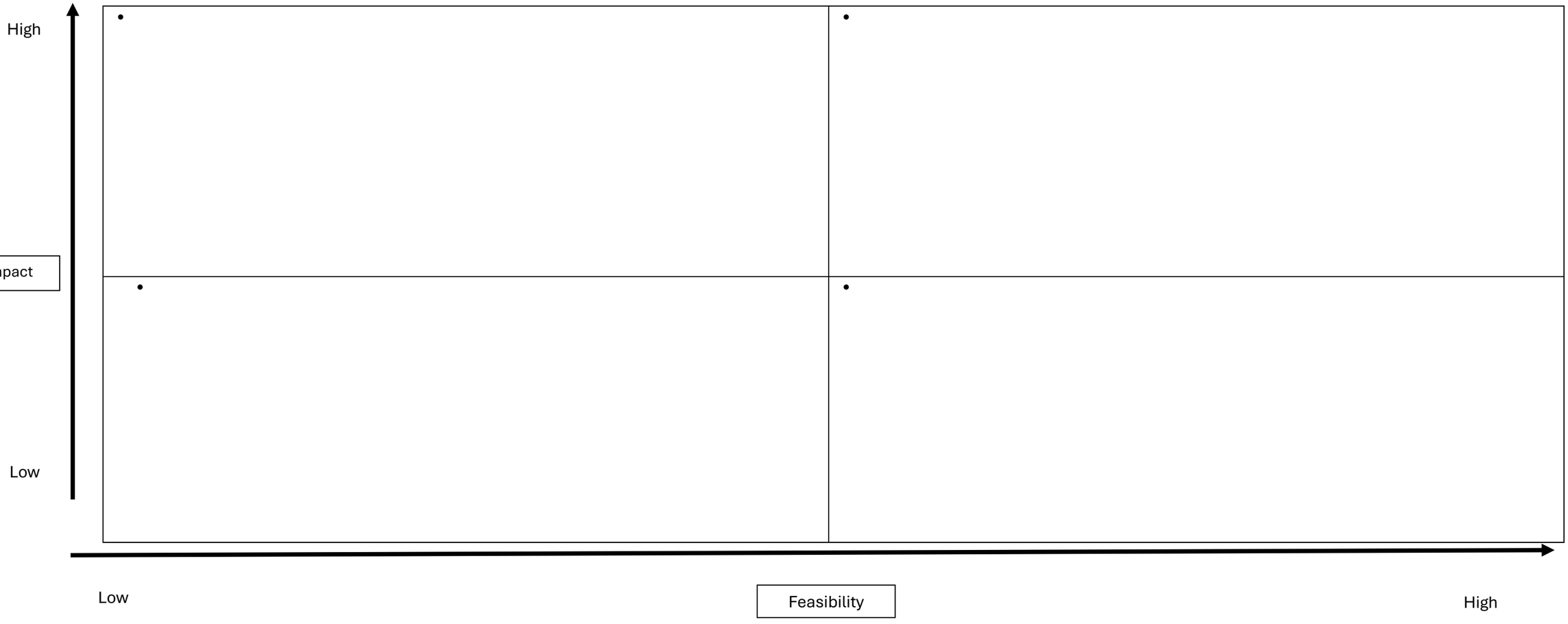
Feasibility vs. Impact Grid

Theme: ASSESSMENT AND EPIDEMIOLOGY



Workgroup process to identify "high impact and high feasibility" workforce planning recommendations

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2. Workgroup members will review the feedback statements.
3. Discuss and come to group consensus for where each statement belongs in the grid.
4. Determine who will report back on the High Feasibility, High Impact results. Facilitator share screen.

FOUNDATIONAL CAPABILITY	PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP	FEEDBACK FROM WORKFORCE ENGAGEMENT SESSIONS
Assessment and Epidemiology	1. **Build a robust data and evaluation workforce:** Increase the number of epidemiologists, data analysts, informaticians, and program evaluators across public health agencies. Advocate for policy changes to allow for remote work positions for data analysts and epidemiologists in rural areas. 2. **Enhance workforce data skills:** Equip public health staff with advanced data analysis skills, including big data, small data, qualitative and quantitative methods, and data justice principles. 3. **Invest in public health education and mentorship:** Expand opportunities for students and early career professionals to gain experience in epidemiology and assessment through internships, fellowships, and mentorship programs.	• **Invest in public health strategies for remote CHW, THW, Doula certification and training programs.** Include continued education with focus on public health assessment and epidemiology related connections with these underutilized yet critical positions for epidemiology in rural and marginalized populations. • **Identify successful strategies for assessment and epidemiology career pathways and ladders, including recruitment and retention in rural and Tribal populations** (such as certifications, community college or educational trainings, lived experience qualifications in job requirements, no cost housing; contracting instead of a straight hire; transportation packages, etc.). Rural and tribal communities specifically struggle with recruitment and retention of these roles. • **Invest in earlier workforce strategies at the high school level.** Dedicate staff to share how public health is working when you don't see it, at local level with system-wide support for growing careers within communities. • **Support public health system workforce approaches to address shortages of epidemiologists, data analysts, research and evaluation that rely on partnerships between workforce employers (OHA-PHD, LPHAs, CBOs, Tribal PH) and academic workforce to**

Feasibility and Impact Activity

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Consensus Decision Making

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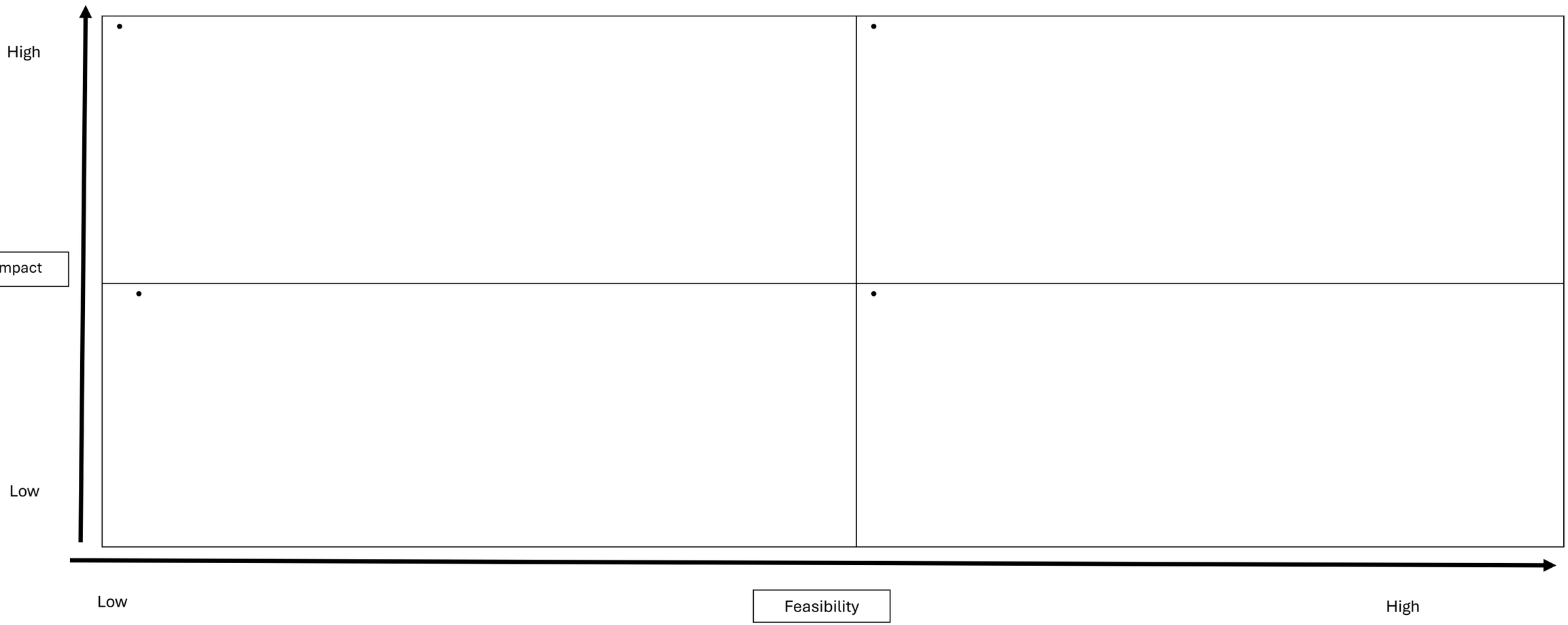
Feasibility vs. Impact Grid

Theme: COMMUNICATION



Workgroup process to identify "high impact and high feasibility"

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Foundational Capability	**PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP**	**Feedback from Workforce Engagement Sessions**

Communication	• **Enhance interagency collaboration**: Develop formal communication channels and collaborative platforms among public health agencies across counties.
	• **Enhance workforce capacity for culturally responsive communication:** Conduct community needs assessments and build partnerships to develop training and resources for the public health workforce on developing clear, culturally appropriate, and timely health messages for diverse communities.
	• **Build workforce capacity for community engagement:** Equip public health staff with skills and resources to effectively engage with diverse communities, including data collection, partnership building, and cultural competency.
		• **Enhance communication and information sharing systems that work across the system.**
		  • For programmatic collaboration and collaborative work across the system.
		  • The incompatibility between institutions' systems causes issues with coordination.
		  • Antiquated systems and processes for document sharing hinders CBOs' ability to serve their communities' needs due to this administrative burden as it results in time spent on finding PDFs, Word documents, emails, etc. and having to ensure appropriate chain of communication via email and document sharing within restrictive platforms.
		• **Dedicate capacity to address communication silos within public health workforce categories and across the system.**
		  • Build connected information sharing systems that work together.
		  • Invest in technology infrastructure for communication and collaboration supporting health education to ensure all communities can benefit from modern public health training, tools and education.
		  • Utilize technology and collaboration across the system to have system level meetings.
		• **Address current challenges in adapting to new technologies and digital tools** that could improve public health education, service delivery and data management.
		• **Invest in communication and promotion strategies to introduce and invite students into the public health field.**
		  • This includes expanding their understanding of public health beyond clinical public health positions, i.e., doctors and nurses.
		• **Address persistent stigma and misinformation about public health services and preventive measures.**
		  • Stigma hinders community engagement and adherence to public health recommendations.
		• **Provide more frequent, consistent, and clear communications in technical assistance** to CBOs.
		  • Provide clear communications to CBOs to reduce ambiguity and communication barriers.
		• **Address inadequate language and accessibility services and resources**; access to interpreters, appropriate language translations, reading level accessibility, physical accessibility.

		• **Public Health trainings are communicated in English. Non-English speaking communities need educational resources, training and professional development opportunities as well.** Working on CHW training (in Spanish). 'Latinx community', as one example, come from many different countries/dialects.

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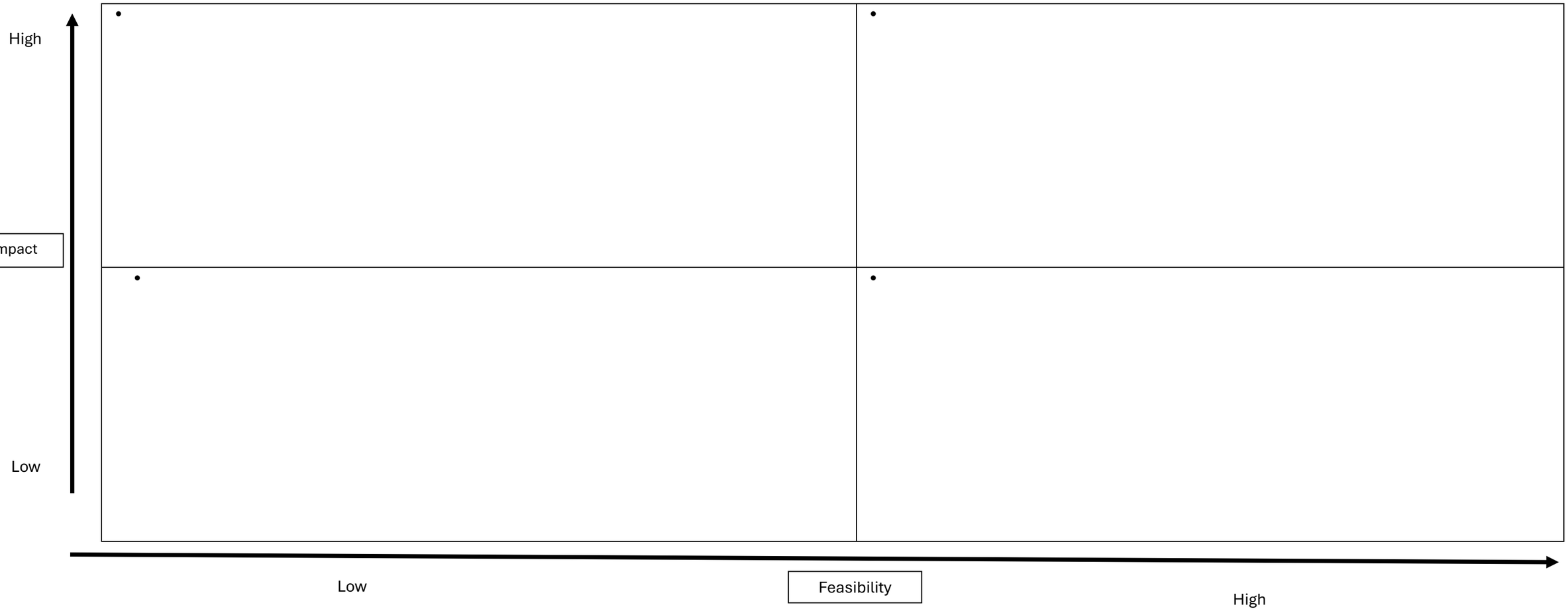
Feasibility vs. Impact Grid

Theme: COMMUNITY PARTNERSHIP DEVELOPMENT



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Foundational Capability	**PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP**	**Feedback from Workforce Engagement Sessions**
Community Partnership Development	1. **Invest in workforce partnership development:** Create dedicated positions and provide training to build and maintain strong partnerships with community organizations. Identify and advocate for long-term funding to support community partnership initiatives. 2. **Expand workforce capacity in rural communities:** Offer targeted recruitment, training, and support for public health staff working in underserved areas. 3. **Develop a framework for partnership evaluation:** Create standardized metrics and tools to measure the impact of community partnerships on public health outcomes.	• **Address insufficient collaboration, and partnerships among public health agencies**, this results in fragmented efforts and reduced effectiveness of partnerships. • **Increase direct outreach and engagement capacity with community** members to better understand and address their specific health needs and preferences. **Enhance flexibility across the system for engaging with and in the community** (relationship building, “reality checking”, getting out of the office, speaking with folks w/out an agenda). • **Invest in planning that develops systems to reduce administrative burdens**. CBOs are burdened with having to explain (at multiple intersections) their **what**, **why**, and **how** in order for state/local public health agencies to approve or understand requests such as those listed on budget line items, or services provided as written in work plans and other reports. Individually, these conversations are not negative, but the *totality* of having to revisit and explain the same services and budget line items to agency representatives takes away valuable time CBO representatives could use to support their respective communities. • **Address high turnover rates at OHA for positions engaging directly with CBOs and their supervisors**. Individual relationship building between representatives and partnership building between OHA and CBOs is negatively impacted by high turnover rates of key positions necessary for smooth transitions and clear communication channels between CBOs and OHA. • **Create strategies with rural and marginalized community partners to address public skepticism** and ambivalence around Public Health. This will build trust and diversity of perspectives in partnership development strategies. • **Improve funding process for CBOs to be less competitive and more collaborative and equitable.** More grants that allow collective/collaborative approach between CBOs and agencies so that funds are distributed more equitably. CBOs loose out on partnership development without funding or when administrative processes suck time away from partnership. • **Earmark funds strategically to develop education, community engagement strategies, and certifications within public health workforce**. There’s a push for really high levels of education, i.e., MD Nursing. Lots of $ goes to these higher levels. However, local community, CHWs, THWs, doulas are needed to ensure partnerships are effective, though, and little funding goes to them.

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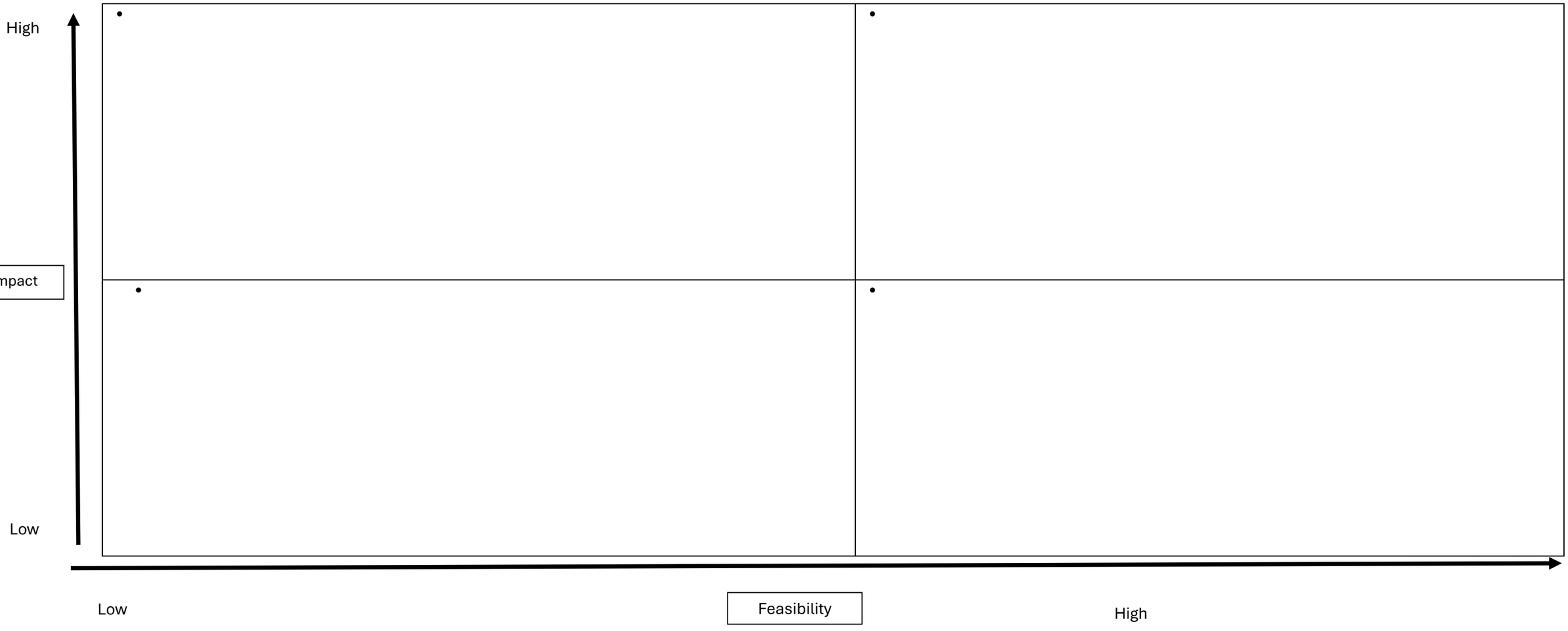
Feasibility vs. Impact Grid

Theme: EMERGENCY PREPAREDNESS AND RESPONSE



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Foundational Capability	**PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP**	**Feedback from Workforce Engagement Sessions**
Emergency Preparedness and Response	• **Expand emergency preparedness workforce training:** Provide access to a variety of emergency preparedness training, including FEMA, first aid, and disaster navigation. • **Invest in emergency response workforce:** Increase staffing levels for critical emergency response positions, such as community health workers, community navigators, and call center staff. • **Enhance workforce capacity for service navigation:** Equip public health staff with the skills and resources to connect community members with essential emergency services and support.	• **Enhance statewide and regional coalitions.** • collaboration and resource-sharing across the public health system • **Support and integrate diverse professionals** including those from immigrant and refugee backgrounds, to better reflect and serve the community in public health emergency work. • **Address regional issues** such as lack of public transportation; folks can't get to the places to access services or work (both community and workforce). Weather like wildfires and high temps are displacing workforce members. • **Analyze funding approach, to address the need for sustainable funding in this capability.** Propose different ways it is allocated based on how many people served by public health regionally. Change the way funding is allocated. Frontier or rural, figure out how to allocate. • **Make curriculum for CHWs, THWs, Doulas designed specifically with and for Latinx people.** All trainings are in English and they are expensive for Latinx communities. Dedicate public health funding to sponsor and expand access to culturally sensitive trainings out of recognition of the critical role this workforce contributes in emergency preparedness and response.

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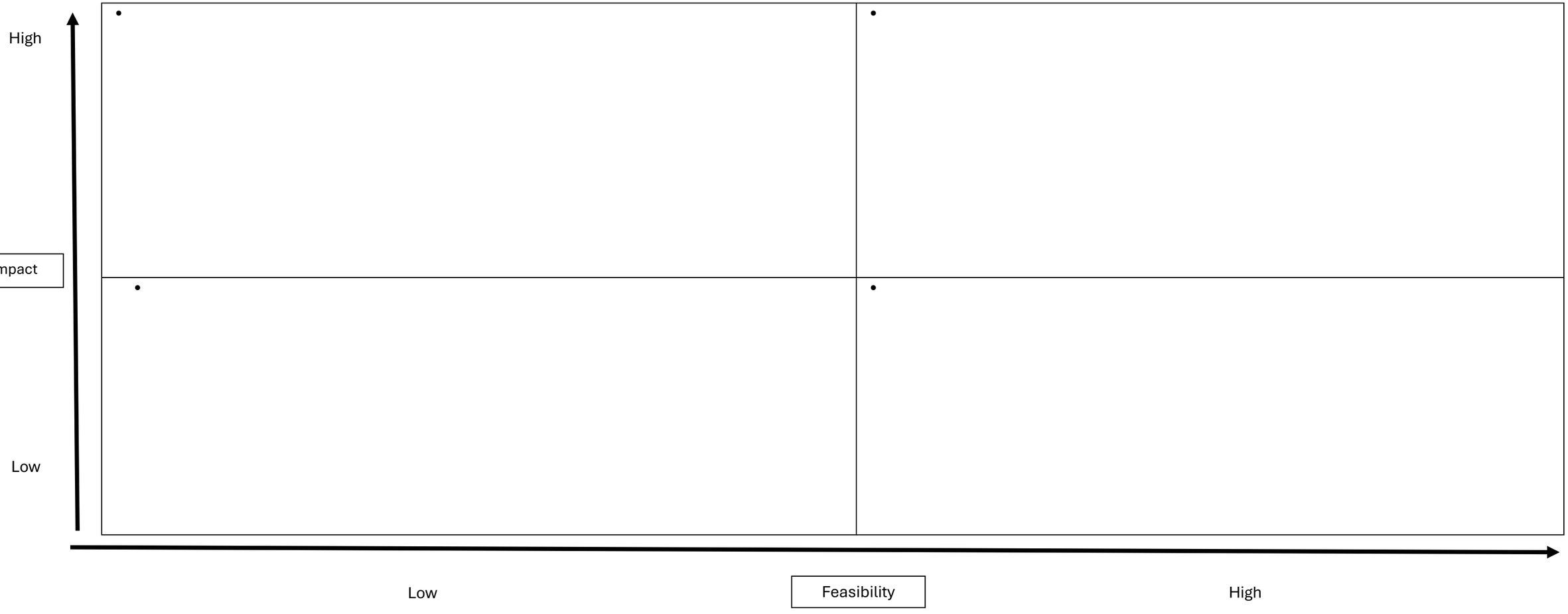
Theme: HEALTH EQUITY AND CULTURAL RESPONSIVENESS



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Foundational Capability	**PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP**	**Feedback from Workforce Engagement Sessions**

Health Equity and Cultural Responsiveness	1. **Diversify the public health workforce:** Invest in programs and initiatives to increase the representation and perspectives of rural communities, tribal communities, people of color and other marginalized groups in the public health workforce.
	2. **Build workforce health equity capacity:** Provide training and development opportunities to equip public health staff with the skills to rectify health inequities and promote health equity.
	3. **Enhance workforce well-being:** Implement strategies to prevent burnout and promote resilience among public health staff working on health equity issues.
		• **Implement workforce hiring and recruitment efforts that reach community with the perspectives, identities, and lived-experience of the community that public health programs, strategies and service are intended to serve.**
		  • Create career ladders and pathways to get these folks in decision making positions where they can accurately represent the folks in their communities.
		
		• **Build cultural competency and responsiveness in existing governmental public health workforce.**
		  • Training for OHA and LPHA workforce lacking awareness of cultural norms, practices, beliefs, values. Partner with CBOs to understand their why, the work they do, and how the work helps to meet the needs of their respective communities.
		  • Provide specialized training for staff in governmental public health to meet the diverse needs of communities, especially new immigrants and refugees.
		  • Staff may require customized support and training tailored to them, their needs, or cultural backgrounds in order to be successful. This may require more time and resources at the beginning of the capacity building process but will result in reducing health inequities over time.
		
		• **Implement consistent training around health equity**
		  • Responsive to changing demographics, cultural education,
		  • Prioritize power sharing,
		  • Address public skepticism or ambivalence around Public Health and health inequities
		
		• **Create workforce partnerships and strategies for diversifying the public health workforce at a system level.**
		  • As an example, CBOs prioritize employment of individuals with direct lived experience; state and local public health may have barriers that CBOs do not.
		  • Invest in workforce training partnerships, CBOs serving 'niche target' populations while OHA and LPHA workforce has limited understanding and awareness of such populations and what it takes to serve them effectively (resulting in health inequities).
		  • Academic partners providing remote trainings and certification to address barriers to access for rural people wanting to have a career in public health but not wanting to uproot and leave their community for education and trainings.
		
		• **Increased access to mental health resources and support for public health professionals**
		  • Address burnout, stress, and other mental health challenges
		
		• **Invest in career ladders for local community to meet public health workforce needs.**
		  • CHWs could be empowered beyond the level of credentialing they have, so rural communities would not need to attract outside workers and could rely on public health workforce already part of the communities in the rural areas needed.

		• "Grow your own" – need more of this in Tribal Public Health, with financial supports and fast track/college. Invest in building capabilities, skills and training of Tribal Members and people already living and part of the Tribal communities. Providing training for community members. • Workforce in rural areas in Tribal communities are often transplants (not from the area that they are serving). This creates transactional based relationships, lacking connection and public health impacts for sustainability with the community. • **Shared knowledge** – the workforce of the public health system does not have a shared understanding of the "public health system". This has impacts on power and positionality and feeds inequities. • **Strategic investment in community health workers for the field of public health** • Life experience and need further education, training and knowledge. • CHWs in public health are fragmented in knowledge making communicating with communities, who also are unlikely to understand public health, even more challenging. • **Invest in CHW and Doula trainings** examples are scholarships from Clackamas County, Legacy Health, etc. Sponsorships and scholarships for workforce development of people living in/from communities with workforce shortages. • **Invest in scholarships and recruitment strategies** to provide access to public health jobs with this foundational capability within rural, Tribal and marginalized communities. • **Dedicate strategies to address barriers to equity and inclusion skills for regulatory public health**, environment requires extensive documentation, Regulatory environment "one-size-fits-all" approach can feel imposed onto CBOs; this can significantly hinder any equity focus CBOs are working on.

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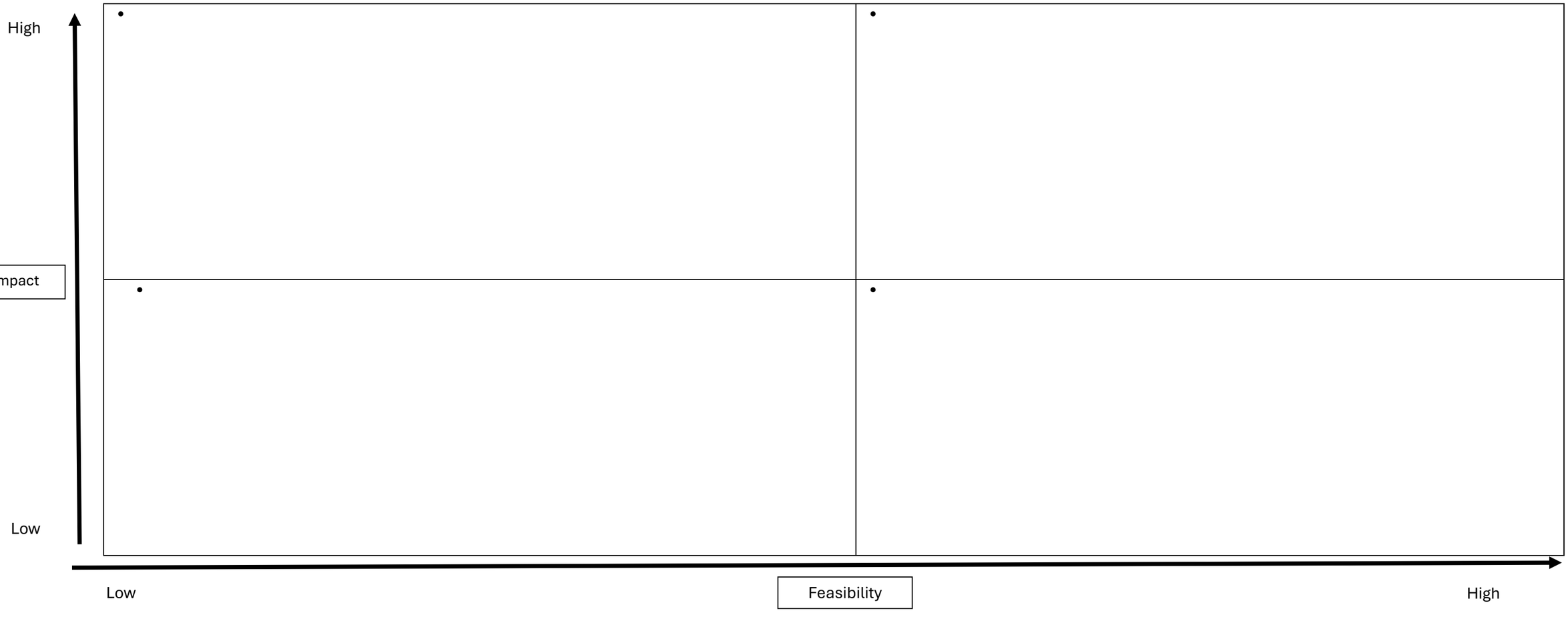
Feasibility vs. Impact Grid

Theme: LEADERSHIP AND ORGANIZATIONAL COMPETENCIES



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Foundational Capability	**PRIORITIZED FEEDBACK COMPLETED BY THE PHAB WORKGROUP**	**Feedback from Workforce Engagement Sessions**

Leadership and Organizational Competencies	• **Develop sustainable public health leadership:** Invest in leadership development programs to prepare the next generation of public health leaders and build sustainable organizational succession opportunities.
	• **Support diverse leadership development & retention:** Create mentorship and sponsorship programs for public health leaders from historically marginalized and underrepresented backgrounds and populations.
	• **Enhance workforce stability & retention:** Implement strategies to reduce turnover and promote long-term career paths in public health.
		• **Create decision making supports for Public Health leaders and decision makers** that ensure policies achieve (and don't counter or exacerbate) equity are applied in an equitable way.
		• **Commission an external party to study public health salaries and benefits for essential public health positions (jobs) across the public health system and identify where competition is occurring that this impacting another part of the system** (for example, people leaving Tribal Public Health Workforce for LPHAs because County Government pays better; people leaving LPHAs to hospitals/health system pays better; etc.). Tailor workforce solutions based on results of the study.
		• **Invest in fiscal analysts and administrative support or systems.** Misallocation of resources and funding, resulting in some areas being over-resourced while others remain underfunded, impacting overall public health effectiveness.
		• **Be more strategic on creating a team of positions (with grant money)**
		• **Invest in governmental systems that remove administrative burdens.** Create a streamlined document submission process. Workplans, reports, budgets, etc. submissions processes must be brought into the 21st century.
		• **Address silos within OHA and LPHAs** which negatively impacts partnerships with CBOs and creates barriers particularly during the workplan and project report processes.
		• **Increase funding and sustainable financial support**, including unrestricted and accessible funding for public health initiatives, capacity in terms of employment, funding, and overall sustainability
		• **Require transparent decision-making processes.** Political intersection with state and local governmental public health – political climate; influences the way that the work can/cannot be done due to commissioners, administrators and directors lack of transparency of who is making decision and the decision making process.
		• **Build skills in public health leadership and workforce for working across different political lines, values, positions.** There is not system-wide support navigating this divide, there is a lot of energy spent in individual areas which could be more effective as coalition work.
		• **Invest in strategies to bring more people into the public health workforce and keep them in public health careers.**
		  • Students
		  • Local people
		  • CHWs, THWs, Doulas
		• **Invest in partnerships and systems for OHA, LPHAs, CBOs and Universities to bring students into the workforce.** Earlier educational opportunities with an emphasis on health equity and systems change; linking up community colleges to provide internships and career relationships. Students are unaware of opportunities in the public health field. Public institutions feel limited in their ability to promote opportunities to students and recent graduates.
		• **Invest in communities of practice for all foundational public health capabilities**. Cohort and peers help each other, share resources, etc
		• **Remove barriers and invest in getting folks within their own communities trained, experienced, and the tools they need to become decision makers for their own communities.** Push more explicitly against white supremacy and capitalism.

		• **Develop a strategy for State and Local Public Health Leadership and power hoarding and workforce not being included in decision-making processes**. • **Partner on policy and funding efforts to support efforts of affordable housing** (provide information and data that justifies this need for public health workforce recruitment/retention and community. • **Provide information and data to agencies and decision makers about how budget (and salary) constraints exacerbate recruitment and retention** (specifically with hiring and), non-competitive salary ranges, and hiring timelines are slow and bureaucratic. • **OHA-PHD continue with dedicating support to make connections for PH strategic priorities with workforce planning clearer for Tribes.**

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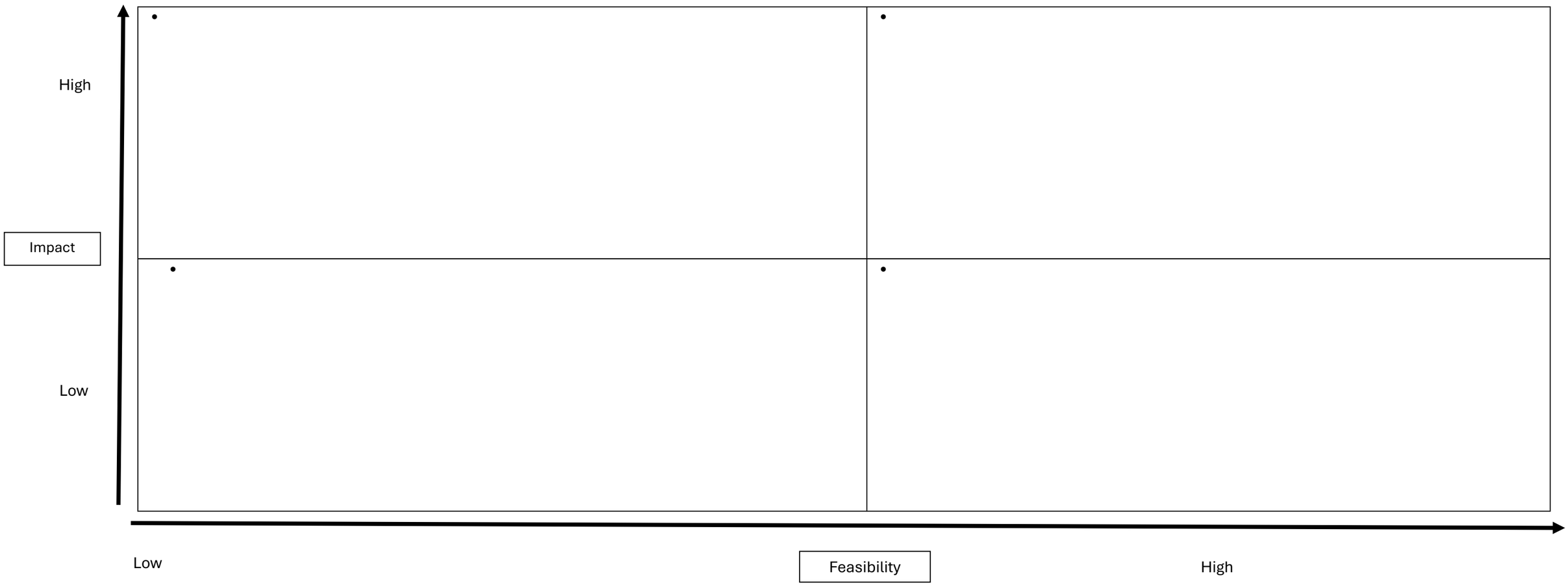
Theme: POLICY AND PLANNING



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Policy and Planning	• **Invest in inclusive strategic planning**: Create a strategic plan for public health that includes input from all relevant partners and contributors across the public health workforce ecosystem.
	• **Enhance workforce capacity for agile planning**: Equip public health staff with the skills and tools to develop and implement flexible systems that address emerging public health challenges.
	• **Address workforce recruitment and retention barriers:** Collaborate with HR departments to remove organizational and institutional barriers to hiring and retaining public health staff.
		• **Make policy and planning connections for strategic initiatives** (SHA/CHA; CHIP/SHIP; PH Accreditation; PH Modernization) **and workforce strategies clearer and responsive to the communication and partnership needs across the public health system.**
		  • Unique to each partner category, as an example this will be different for Tribes
		• **Implement intentional strategies to counter polarization across the public health system for policy and planning.**
		  • Political climates impact partnerships between OHA, LPHA and CBOs', this impacts CBOs ability to serve the needs of their communities.
		  • Policy efforts that support public health infrastructure and workforce needs, ensuring that public health concerns are prioritized at all levels of government.
		• **Enhance and invest in strategies that build workforce foundational capabilities, skills and training for**
		  • Tribal communities
		  • Rural communities
		  • Underrepresented and marginalized communities
		• **Advocate for funding that is sustainable to fulfill the foundational capabilities**.
		  • Funding timelines are every 2-4 yrs (with elections, legislative sessions, federal grant timelines), Foundational capabilities, the skills and contributions that public health workforce needs to make remain the same regardless of funding provided.
		  • Develop materials that educate and inform the legislators and commissioners about what is needed for sustainable funding to address public health workforce needs (challenges to recruit for positions that are 100% grant-funded with short-term timelines that don't sustain/retain a permanent employee.)
		  • Convene a public health policy coalition that supports collaborations across the system to align and accomplish shared public health policy goals.
		• **Demonstrate need to fund programs and increase general salaries** for entry level positions and upward. Increase scholarships and tuition assistance to complete Masters in Public Health programs.
		• **Address administrative burdens.**
		  • Report writing and workplan submission processes negatively impact LPHA and CBOs' ability to serve their respective communities.
		  • As subrecipients, and grantees, LPHAs and CBOs create workplans, budgets, and reports for OHA, but the person(s) reviewing these documents aren't always familiar or knowledgeable about LPHA or CBO work.
		• **Address workforce shortages through intentional recruitment and retention strategies that support staying in or relocation to small, rural and Tribal communities.**

		• Examples: tuition reimbursement, healthcare package, childcare, housing, public health leadership support for investments in rural and Tribal community infrastructure (to interest and retain local and transplant public health workforce). • This supports transitions for students moving into these communities, from education to a career. • This can also support career development of CHWs, doulas and non-degree community members who could be qualified to do public health. • **High turnover rates impact ability to communicate within and among agencies and creates challenges with communication across the public health system.** • Address planning and policy needs for retention efforts that ensure partnership roles are part of position duties/requirements. • **Invest in public health agency policy and partnership efforts with CCOs.** • CCOs have funding pertaining to public health priorities. • Need to identify CCO/Public Health resource sharing opportunities. • **Develop and promote policies that fund internships across the public health system (state and local gov't public health,** CBOs and Tribes) and build relationships with academic institutions that offer public health education so students who enter the Public Health workforce after graduation have real-world job experience. • Paid placement for students, • Create internships for older high school students, • Develop work ready adults in their communities, • Support sponsor/preceptor/mentorship opportunities professional who cares about them. • **Plan incentivized continuing education (CE) and certifications to create ladders and keep up with evolving needs for professional development at various levels of education.** • Community health workers need a ladder, opportunities, that don't require masters. • Existing workforce lacking adequate educational training • Fill workforce gaps in underrepresented, rural and Tribal communities. • **Public Health academic workforce advocate for internal policies with institution decision makers** • **to offer virtual courses, trainings, badges, certificates, etc.** • Address geographical access constraints for small, rural, Tribal communities • Responsive to socio-cultural-educational-economic linguistic needs of marginalized communities • MPH Program for Health management and policy doesn't have a single class about how a public health department works. This should be a part of core education.

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