PHAB Public Health System Workforce Workgroup

– Prioritized Needs by Foundational Capability** –

** The draft ranked compilation of priorities are for use as reference and reflection to inform workforce plan recommendations. They are not final or official.

Foundational Capability	PHAB Workgroup Top 3 Priorities	Priorities from Workforce Engagement
Communication	1. **Enhance interagency collaboration**: Develop formal communication channels and collaborative platforms among public health agencies across counties. 2. **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. 3. **Build workforce capacity for community engagement:** Equip public health staff with skills and resources to effectively engage with diverse communities, including data	1. **Dedicate capacity to address silos.** OHA public health program silos (internally) and silos between OHA and LPHAs. The silos exacerbate unclear information from OHA for CBOs. Build connections, institutions are not able to work together, their information systems don't work together, this impacts academic partnerships for public health career paths. 2. **Invest in communication strategies to introduce and invite students into the public health field.** This includes expanding their understanding of public health beyond medicine, i.e., doctors and nurses.

	collection, partnership building, and cultural competency.	3. **Address persistent stigma and misinformation about public health** services and preventive measures, which can hinder community engagement and adherence to public health recommendations. 4. **Invest in technology infrastructure and health education** to ensure all communities can benefit from modern public health tools and information. Utilize technology and collaboration across the system to have system level meetings. 5. **Address current challenges in adapting to new technologies and digital tools** that could improve public health education, service delivery and data management. 6. **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. 7. Enhance systems – The incompatibility between institutions' systems causes issues with coordination. Students find it discouraging to be trained in one system then have to learn an entirely different one. 8. CBOs could benefit from a reduced administrative burden, freeing up time to increase capacity and serve their communities. 9. **Provide more frequent, consistent, and clear technical assistance** to CBOs. 10. **Provide clear messaging** to CBOs to reduce ambiguity and communication barriers.

		11. **Address inadequate language and accessibility services and resources**; access to interpreters, appropriate language translations, reading level accessibility, physical accessibility.
Policy and Planning	1. **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. 2. **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. 3. **Address workforce recruitment and retention barriers:** Collaborate with HR departments to remove organizational and institutional barriers to hiring and retaining public health staff.	1. **Intentional strategies for collaboration to counter polarized political climates.** Political climates impact partnerships between OHA, LPHA and CBOs', this impacts CBOs ability to serve the needs of their communities. 2. **Enhanced advocacy for policies that support public health infrastructure and workforce needs,** ensuring that public health concerns are prioritized at all levels of government. 3. **Uncertainty around funding programs makes it difficult to plan for sustainability**. Things

		change every 2 – 4 years (with elections and legislative sessions), complicating the uncertainty around funding and sustainability. 4. **Address administrative burdens.** Report writing and workplan submission processes negatively impact CBOs' ability to serve their respective communities. CBOs create workplans, budgets, and reports to be sent to OHA, but the person(s) reviewing these documents may not be knowledgeable about CBOs' work. 5. **Address workforce recruitment/retention through intentional strategies** to support relocation to small, rural communities, leading to workforce shortages. Tuition reimbursement, healthcare package, childcare, housing. To transition students from education to a career. For career development of CHWs, doulas and non-degree

		community members who could be qualified to do public health. 6. **Paid placement for students**, extension partner, internship for older high school, serves many purposes, paid, career direction, in under resourced area, people don't have a lot of connections, powerful in setting life. When developing work ready adults who want to stay, need to experience and have an adult their care about them. 7. **Collaborate across the system on strategic and ongoing training and professional development** opportunities for keeping up with evolving public health needs and maintaining public health job satisfaction. Incentivize continuing education, ladders for professional development, diversity of degrees, community health workers that need a ladder, opportunities that don't require masters degree.

		8. **Dedicate efforts to address equity and inclusive 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.
Health Equity and Cultural Responsiveness	1. **Diversify the public health workforce:** Invest in programs and initiatives to increase the representation of people of color and other underrepresented 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 address health disparities 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.	1. **Address workforce lack of cultural competence** and specialized training to meet the diverse needs of communities, especially new immigrants and refugees. Hiring workforce among the community with the perspectives, identities, lived-experience of the community they are working in/for. 2. **Invest in trainings**, 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). 3. **Invest in workforce capacity building**, 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 improve health inequities over time. 4. **Increased access to mental health resources and support for public health professionals** to address burnout, stress, and other mental health challenges. 5. **Invest in career ladders for local community health workers** 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" – fast track/college

		6. **Shared knowledge** – workforce does not have a shared understanding of the "public health system". This created disconnect when workers contact different agencies and localities using different terminology and acronyms. 7. **Strategic investment in community health workers who come into the field of public health** with life experience and need further education, training and knowledge. Public health workers being fragmented in knowledge will make communicating with the public, who also is unlikely to understand public health, even more challenging. 8. **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.

		9. **Implement consistent training around health equity, changing demographics and cultural education, and prioritize power sharing**.
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.	1. **Address insufficient collaboration, and partnerships among public health agencies**, that result in fragmented efforts and reduced effectiveness of partnerships. 2. **More direct outreach and engagement with community** members to better understand and address their specific health needs and preferences. 3. **Invest in planning that develops systems to reduce administrative burdens**. CBOs being 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. 4. **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. 5. **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).
Emergency Preparedness and Response	1. **Expand emergency preparedness workforce training:** Provide access to a variety of emergency preparedness training, including FEMA, first aid, and disaster navigation. 2. **Invest in emergency response workforce:** Increase staffing levels for critical emergency response positions, such as community health workers, community navigators, and call center staff. 3. **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.	1. **Create of statewide and regional coalitions** to enhance collaboration and resource-sharing among public health agencies. 2. **Support and integrate diverse professionals** (ex. THWs, CHWs, doulas) including those from immigrant and refugee backgrounds, to better reflect and serve the community. 3. **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.
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.	
Leadership and Organizational Competencies	1. **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. 2. **Support diverse leadership development & retention:** Create mentorship and sponsorship	1. **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. 2. **Be more strategic on creating a team of positions (with grant money)**

	programs for public health leaders from historically marginalized and underrepresented backgrounds and populations. 3. **Enhance workforce stability & retention:** Implement strategies to reduce turnover and promote long-term career paths in public health.	3. **Increase funding and sustainable financial support**, including unrestricted and accessible funding for public health initiatives, capacity in terms of employment, funding, and overall sustainability 4. Local politics – political climate; the way that the work can/cannot be done due to commissioners and other figureheads; lack of transparency of who is making decision. 5. In addition to political climate, feeling trapped between two very different political positions is the second challenge. Feeling that not only is there not support navigating this divide, there is a lot of energy spent needing to explain (feeling like the anomaly). 6. **Invest in strategies to bring more people into the public health workforce and keep them in public health careers.** a. Students b. Local people c. CHWs, Doulas

		7. **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. 8. **Invest in communities of practice for all foundational public health capabilities**. Cohort and peers help each other, share resources, etc.

Purple – CBO

Red – Tribal PHM Grantees/THDs

Blue – LPHA

Green – ACADEMIA

Orange - OHA

Black - Unidentified workforce category (Unicorns)

Additional feedback from community engagement sessions:

- People seemed really excited to be in the same room together.
- There were old colleagues who hadn't seen each other in awhile, reconnecting. "We need more reasons like this to come together."
- One of the participants said the following quote that moved the group in a powerful way: "The day black serving, black led organizations are able to do their job to the best of their ability without having to worry about funding is a sign the Public Health Workforce has made great progress."
- High turnover rates appear to impact OHA's ability to communicate within and among agencies, and as a result challenging communication between agencies and CBOs as mentioned above.
- When OHA representatives do foster relationships with CBOs, the impression is that it is usually as a result of the individual investing their time and efforts into building these relationships rather than it being part of the position's requirement. This creates a challenge, as high turnover rates of key positions does not ensure a consistent effort of relationship and partnership building between OHA and CBOs.

Cultural competency:

- OHA and LPHA contacts are not aware of what CBOs actually do, why CBOs do this work, and how the work helps to meet the needs of their respective communities.
- OHA and Local Public Health lack of understanding, awareness, and knowledge around the needs of impacted populations across Oregon creates challenges related to improving workforce capacity, particularly when CBOs prioritize employment of individuals with direct lived experience.

Remove Administrative Burdens:

- Create a streamlined document submission process
- Workplans, reports, budgets, etc. submissions processes must be brought into the 21st century.
- OHA and LPHAs operate in siloes, which negatively impacts partnerships with CBOs and creates barriers particularly during the workplan and project report processes.

- The Legislature gives OHA new tasks but:
  a) do not always provide funding for these additional assignments and/or
  b) do not provide guidance on how to best incorporate these new tasks into existing programs, or
  c) do not provide guidance on how to best incorporate these new tasks into the agency's structure while also having to mitigate other programs that could potentially be affected or impacted by the new task assigned to the agency.
  This creates and/or exacerbates barriers experienced by CBOs in terms of their abilities to communicate with OHA and receiving clear instructions and overall messaging from OHA.

- Workforce capacity – workplace environment is stressful and spread thin, lack of training opportunities, power hoarding (politicians); workforce not included in the decision-making processes
- Lack of affordable housing (workforce and community) – so much energy is spent just trying to survive
- Budget constraints (salaries); specifically with hiring. And hiring timelines are slow and bureaucratic which is exacerbated by the budget constraints.

- Workforce are transplants (not from the area that they are serving). There's not as much connection to the community.

- Things to do at high school level, public health is working when you don't see it, but you need to integrate, could happen at local level with support.
- MONEY!
- More flexible hiring requirements, where we put the resources, grants and contract issues to one INST, incentive to work across silo, needs to be the norm. Calls with multiple sites, demonstrate.
- Invite students to consider public health!
- Transitioning folks, incentivize continuing education, incentive for CE, ladders for professional development, diversity of degrees community health workers that need a ladder, opportunities, that don't require masters. Stop in progression where they can't be supported. Broaden scope, fill gaps in rural areas. Be the adult that is showing the career that we can do.
- Funding allocation, creating opportunities, how do we sustain them. Always on a grant at state of job, limited duration, depending on grant. Sustainable funding, different ways it is allocated, how many people in the area. Changes to the way it is allocated. Frontier or rural, might not need to funding proportion. Figure out how to allocate.
- Valid points, see things people are talking about, needing to improve, lack of resources, funding. See behind sense THW programs, some type of communication collaboration among the trainings, effective with collaboration, communication in this area, to another section of the area. Opportunities after completing the training.
- Got to the heart to issues very quickly.
- Realizing that need to get together, OHA is listening. Would love to see other institutions represented.

- Pro: Project expending OHA to individual regardless of status. Language equity. Community advisory board.

- Want equity policies to be applied in an equitable way
- OHA provides Latinx community doula certification, but folks can't work if they don't have social security
- Less competition, more grants that allow collective/collaborative approach between CBOs and agencies so that funds are distributed more equitably.
- Scholarships and recruitments to provide access to these professions
- Filling positions in Coos Bay due to housing availability. This includes neighboring cities like Bandon, Florence, Eugene
- Attracting workers into a community that is both a viable place to both live and work
- Need more sponsors for health. All trainings are in English. Latino community needs help. Working on CHW training as well (in Spanish). Latino community comes from many different countries/dialects
- Doulas/community workers are the people who can help. Trainees need to get to them.
- Try to make curriculum designed specifically for Latino people, culturally sensitive
- All trainings are in English and they are expensive for Latino communities. We need more sponsors to spread these trainings
- Recognizing unique sectors at play and not forcing them to compete with one another for funding. There are some things CBOs can help with. Communities training one another should be good, but orgs sometimes come in and try to re-do process
- People are qualified in CBOs, but agencies don't take the lived qualifications seriously. Return of investment over time would be really high if we thought long-term, not just 1 or 2 year grant cycles
- Public health agencies partner with CCOs for funding. Hopefully get the dollars out the door in different ways. Make connections for more opportunities.

- Sometimes we have to reject doula candidates because they don't have social security (which impedes them from being hired by LPHAs)
- There's a push for really high levels of education, i.e., MD Nursing. Lots of $ goes to these higher levels. However, doula/community healthcare workers are needed, too, though, and little funding goes to them. Need to earmark funds strategically to develop the education, community engagement, certifications within public health workforce.

- Regionally
  - Lack of public transportation; folks can't get to the places to access services or work (both community and workforce).
  - People are leaving the area and new people aren't coming in.
  - Some areas don't have a local public health educational program and so folks from the community have to leave to get their degrees before they can return to their area, and sometimes they end up not returning.

Retaining staff, keeping qualified staff in Tribal health dept, salaries, competitive in Central Oregon, trying to keep people in Tribal Health Dept, competing with Federal HIS, hospitals, salaries. Tribal Medical PH employees – tuition reimbursement, healthcare package, childcare, housing on the Reservation (not a lot of folks want to live on the reservation)

Recruitment of qualified workforce, we will often have only 1 candidate for an open position. I don't think this is a top need, but still a barrier. 30 cents off a gallon, PTO is better than with the hospital – drastic change in schedule from 3 days a week to 5 days a week. Getting the staff to stay.

It can be challenging to recruit for a position that is 100% grant-funded, and you don't know how long it will be around. Internal approval process. Communication with other local organization that are trying to accomplish the same public health goals.

“Grow your own” – fast track/college