Oregon Public Health System Workforce Feedback Collected by OHA Aug-Sept 2024

State Public Health Workforce Feedback

8/1/2024 – Public Health Modernization Chat

1. What are the biggest challenges or obstacles preventing our public health workforce from effectively doing their jobs and meeting community needs?

- People are spread thin. Many people are covering a higher workload than is appropriate for one person
    - The way the agency is set up makes it difficult to build relationships with communities which is essential, but now building those relationships from scratch → huge lift for that; to be able to build those relationships we need the staff and to invest those staff to make
    - Even people who work with communities who work to make policies for the communities are not necessarily doing so through a relationship-building, and community-centered process
    - Limitations & issues we've encountered are limited staffing and unconsciously we set ppl up for failure by starting them off with too much from the beginning → the work is urgently needed but it is too much for the available staff, so people are asked to do more than is realistic from the start.
- Programs and people are siloed. A barrier we continue to see is that a lot of team/positions (perhaps the way that the agency is structured) is very siloed. Many of us were hired during the pandemic and work virtually which makes it very difficult to know what other people are working on; there appears to be a lot of duplication and discovery that happens that people are doing related work (already)
    - Exciting that there is an influx of new staff but also lots of leadership transition
    - A meeting like this that convenes many different types of PH practitioners but they are still segmented when it comes down to actual discussions → also the fact that there are only 20 ppl from OHA and this is only a small fraction of the agency
    - Cited PHA Modernization key takeaways – silos were mentioned → organizational and relational silos needed to be bridged
- Achieving ambitious workload typically requires an exceptional/extended effort at the individual level. and It's also very hard to carry partnerships without inadequate FTE; it really falls on the individual who goes that extra step and effort to facilitate those partnerships and helping those partnerships flourish, which leads to true shared leadership and collaboration; it requires alignment of your work, positionality, intention, but also the appropriate amount of time and resources → very reliant on individual efforts/connectors
- How we collect and report data causes harm to communities. Continuing to build the technology infrastructure because people struggle → part of the grant funding process requires the regular creation & completion of progress

reports; the learning curve can be very difficult and tedious to both administer and complete (at all levels)

2. What specific resources, support, or changes are needed to strengthen our public health workforce and improve public health outcomes?

- Intentional resourced partnerships between OHA, local health depts, and universities to bring students into the workforce
    - [copied from the chat]: *I love that idea! In a past role I worked on nurturing an academic health department in the area of climate and health (Pima County Health Dept/University of Arizona) https://www.phf.org/programs/AHDLC/Pages/Academic_Health_Departments.aspx*
- Need technology to make it easier to have meetings like this- progress has been made but it takes a lot of resources (i.e. facilitators) to run this meeting; we are also very short on fiscal analysts, administrative support
- Grant funding that supports programs and new teams should that is a composite of both direct service and administrative, supportive infrastructure type positions. Grant money is typically used for direct services workforce rather than overhead and administrative supportive roles → we need to be more strategic in how we build money into these grants → its typically built as 1 to 1 → need to be more strategic on creating a team of positions (with grant money)

Other:

- Diversity in the workforce can be a double-edged sword. i.e. if/when a BIPOC immigrant takes up the position goes to rural Oregon and tries to build relationships, they will experience unique barriers
    - Solution would be hiring workforce among the community and reflect the perspectives, identities, lived-experience of the community they are working in/for

Local Public Health Workforce Feedback

8/1/2024 – Public Health Modernization Chat

1. What are the biggest challenges or obstacles preventing our public health workforce from effectively doing their jobs and meeting community needs?

1. 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.
2. Workforce capacity – workplace environment is stressful and spread thin, lack of training opportunities, power hoarding (politicians); workforce not included in the decision-making processes
3. Lack of Language and accessibility services and resources; access to interpreters, appropriate language translations, reading level accessibility, physical accessibility.
4. Lack of affordable housing (workforce and community) – so much energy is spent just trying to survive
5. "I would like to add that 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. Workforce are transplants (not from the area that they are serving). There's not as much connection to the community.
7. 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.
    - Weather like wildfires and high temps are displacing workforce members.
    - Budget constraints (salaries); specifically with hiring. And hiring timelines are slow and bureaucratic which is exacerbated by the budget constraints.

2. What specific resources, support, or changes are needed to strengthen our public health workforce and improve public health outcomes?

1. Earlier educational opportunities with an emphasis on health equity and systems change; linking up community colleges to provide internships and career relationships.

2. Consistent training around health equity, changing demographics and cultural education, and
3. Prioritization of power sharing.
4. Flexibility to engage in the community (relationship building, "reality checking", getting out of the office, speaking with folks w/out an agenda).

Other:

OHAs communities of practice are amazing; would like to have more of them for the various practice areas. Cohort and peers help each other, share resources, etc.

Community Based Organizations Public Health Workforce Feedback

8/1/2024 – Public Health Modernization Chat

1. What are the biggest challenges or obstacles preventing our public health workforce from effectively doing their jobs and meeting community needs?

1. Reluctance to relocate to small, rural communities, leading to workforce shortages.
2. Lack of cultural competence and specialized training to meet the diverse needs of communities, especially new immigrants and refugees.
3. Insufficient partnerships, collaboration, and cohorts among public health agencies, resulting in fragmented efforts and reduced effectiveness.
4. Challenges in adapting to new technologies and digital health tools that could improve service delivery and data management.
5. Inadequate ongoing training and professional development opportunities, leading to difficulties in keeping up with evolving public health needs and maintaining job satisfaction.
6. Misallocation of resources and funding, resulting in some areas being over-resourced while others remain underfunded, impacting overall public health effectiveness.
7. Persistent stigma and misinformation about public health services and preventive measures, which can hinder community engagement and adherence to health recommendations.

8. Lack of capacity in terms of employment, funding, and overall sustainability.

9. CBO member(s) agreed that working with OHA and/or local Public Health Offices as a CBO can be quite difficult, cumbersome, slow, and complicated. This seems to be exacerbated by several barriers to include the following:

10. CBOs serving 'niche target' populations versus OHA's and Public Health Offices' understanding and awareness of such populations and what it takes to serve them effectively:

    a. OHA and Public Health 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.

    b. OHA and 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.

11. OHA and Public Health Offices either not understanding or not being knowledgeable about the work CBOs they partner with or their purposes and services they provide, negatively impacts the way OHA and Public Health interacts with *and* communicates with CBOs (particularly CBOs providing highly specialized services):

    a. For example: OHA representatives who interact with CBOs having no, or little, understanding, knowledge, and awareness of life-span and/or complex conditions experienced by populations creates a multitude of barriers and challenges to include CBOs being burdened with having to explain (at multiple intersections) their **what**, **why**, and **how** in order for 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.

        i. This problem, for the most part, is mitigated fairly quickly after CBO and agency contact connect and CBOs are able to explain the services they provide to the agency. The cumbersome part, however, is having to explain these services as well as the *what, why, and how* to multiple people, multiple times, throughout the timespan of a single work project. Individually, these conversations are not negative per se, 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.

12. High turnover rates at OHA (particularly in positions engaging directly with CBOs and their supervisors):

    a. 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.

    b. 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.

    c. 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.

13. OHA and Public Health operate in siloes, which negatively impacts partnerships with CBOs and creates barriers particularly during the workplan and project report processes:

    a. CBOs may work with populations who navigate touch points at various intersections of OHA and other agencies or cannot simply be assigned to a single predetermined silo within agencies. However, agency programs appear to operate within their respective departments and often seem unaware of other related programs, especially when these are not operated under the same department. This significantly complicates working relationships and communications with CBOs and results either in complete communication breakdowns with no resolutions for the CBOs' questions or challenges, or, at minimum, creates a significant delay in receiving answers. This, then, complicates CBOs' abilities to adjust workplans, if necessary, in a meaningful, effective, and equitable manner.

    b. For example, a lack of understanding and knowledge around lifespan and complex conditions (mentioned under #2.) fuels these barriers to the extent that CBOs' representatives must take additional time to navigate these siloed communication channels and (re)explain the purpose of their services multiple times throughout the project or budget cycle.

    c. Silos negatively exacerbate unclear messaging by OHA for CBOs.

14. Excessive regulatory environment negatively impacts CBOs' ability to effectively serve 'target' populations:

    a. Excessive regulatory environment requires extensive documentation, but CBOs not always sure how useful the required information is.

    b. Such an environment appears to feed a "one-size-fits-all" approach and can feel imposed onto CBOs; this can significantly hinder any equity focus CBOs are working on.

15. Report writing and workplan submission processes negatively impact CBOs' ability to serve their respective communities:

    a. 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. (See #2 through #4 for context)

    b. The actual process of writing and updating these documents seems quite outdated and adds significant administrative burden to the process. The antiquated process of writing and updating documents

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.

16. Political climates impact CBOs' ability to serve the needs of their communities:
    a. Polarized political climates impact the way OHA and Public Health Offices interact with and communicate with CBOs
    b. Uncertainty around funding guarantees for programs makes it difficult to plan for sustainability.
    c. Things change every 2 – 4 years (with elections and legislative sessions), complicating the uncertainty around funding and sustainability.
17. Unrealistic timelines imposed onto OHA (by Legislature) *or* created by OHA negatively impacts partnerships with CBOs and generates even more unrealistic timelines on CBOs' ability to serve their respective communities in an equitable manner.
    a. These unrealistic timelines are exacerbated by the siloed structures of OHA and Public Health and additional barriers (see notes #2 through #6).
18. The *totality* of these challenges and barriers negatively impacts CBOs' ability to provide consistent, effective, and equitable services to their respective communities.

2. What specific resources, support, or changes are needed to strengthen our public health workforce and improve public health outcomes?

1. Creation of statewide and regional coalitions to enhance collaboration and resource-sharing among public health agencies.
2. Programs to support and integrate diverse healthcare professionals, including those from immigrant and refugee backgrounds, to better reflect and serve the community.
3. Enhanced advocacy for policies that support public health infrastructure and workforce needs, ensuring that public health concerns are prioritized at all levels of government.
4. Investments in technology infrastructure and health education to ensure all communities can benefit from modern public health tools and information.
5. More direct outreach and engagement with community members to better understand and address their specific health needs and preferences.

6. Increased funding and sustainable financial support, including unrestricted and accessible funding for public health initiatives.
7. Increased access to mental health resources and support for public health professionals to address burnout, stress, and other mental health challenges.

Other:

- 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."

9/19/2024 CBO Advisory Board Meeting

1. Any grant to a nonprofit, or contract based on actual spending rather t han set consulting rates, should include a set 15% indirect rate (match ing the new federal De Minimus rate) or the organization's NICRA if the y have one. The organization should determine what costs are direct a nd what are indirect based on their cost allocation plan. The state coul d develop a sample cost allocation plan in accordance with federal guid elines that could be used if the organization doesn't have one that mee ts federal guidelines. An organization should be able to use one plan ac ross all OHA grants and contracts.
2. The state should publish annually or in each RFP wage guidelines base d either on a living wage calculator, or on what state workers would m ake at a similar responsibility level. The granting agency should encour age organizations to propose budgeted wages in line with these guideli nes. Fringe rate ranges or costs they expect to see for benefits should also be communicated, to allow organizations to offer robust benefit pa ckages.
3. Spending reports, invoices, and reimbursement requests should be sim plified and standardized across each state agency rather than at the pr ogram or department level.
4. Competing with bigger agencies for grant money. If you are a cbo that has worked with the state for an x amount of time, you should have a base set funding
5. Continuing to resource efforts to streamline funding
6. Workforce plan that fosters emergence of leaders in isolated communities that can make necessary connections in time of crisis
    a. Community based organization fostering the emergence of leaders

    b. Fostering network of informal leaders that make connections to public health
    c. Programs for younger people in community encouraging them to pursue behavioral health careers
    d. Nonprofits should be allowed to profit, shortchanged in comparison to contractor
    e. Emergency preparedness piece (wildfires, power outage, COVID)
7. Trainings, statewide leaders to be trained on emergency preparedness for things that are climate change related
8. Struggles with FEMA and language barriers
9. Cultural responsiveness for emergencies Languages and different community leaders that speak other languages trained on emergency preparedness
10. Funds to CBO’s to award scholarships to their community members

Academic Public Health Workforce Feedback

8/1/2024 – Public Health Modernization Chat

1. What are the biggest challenges or obstacles preventing our public health workforce from effectively doing their jobs and meeting community needs?

- High level challenges – Fractures in public health was a commonly cited challenge. Institutions are not able to work together, their information systems don't work together. Training presents failure points in transitioning students from education to a career.
- Knowledge – Respondents felt that that public health workers did not understand "public health" at the same level. This created disconnect when workers had to contact different levels and areas, different agencies and localities use different terminology and acronyms for example. Some community health workers come into the field with life experience, which is a positive, but need to have the same level of 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.
- Training – 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. Agencies don't know how to market the field to students. Students face many barriers outside of educational institutions, for example if they get a good internship, they many not be able to find housing. The uncertainty and limitations of grant funding also mean students are weary to settle in some areas.
- Rural – Rural communities are facing challenges of separation, attracting talent, and keeping workers in rural communities. Lack of housing in rural areas is an important driver of this issue, it is hard for new health workers to establish themselves in these communities. Limitations inherent in certain credentials also restrict the ability of those workers already in rural areas. There is a lack of knowledge in rural areas about public health, limiting local interest in the field.
- Systems – The incompatibility between institutions' systems causes issues with coordination. Students also find it discouraging to be trained in one system then have to learn an entirely different one.

Other:

- Tough, not inside, what hearing, sounds challenge getting everyone on same level of understanding and knowledge working in public health. Basic information, public health, local acronyms, state ones, tools. Baseline, how to function in public health departments, that surround public health departments. Unique way to help. Having everyone, same level, the workers. Does the public understand public health.
- Community health worker, health worker training, agree, apart resonating with, some come with lots of life experience, but need to work in spaced, not sure what public health is, how to describe, need additional training, public health, department CBOs, what is preventing them, even getting that basic training and knowledge in public health when entering. Several other challenges.
- At beginning of covid training students, case investigations. Students working antiquated systems, lack of investment. Inflexible systems, data systems that make work hard. Job are too big for time staffs, perpetual burnout.
- Echo, add layer, every system has it sown complex system that doesn't interface, students struggle to get up to speed with own system and then the large government agency are their own beast, discouraging, wouldn't expect them to be same, **fragmented**. Don't transfer knowledge Jobs are big, effort is small, don't have capacity to be oriented feel welcome. People knew don't experience. Alienated. 100% agree
- 100 undergrads in programs, have opportunities around graduation, looking to move in career, rural county HR. Can improve, connection undergrad and post grads looking for careers. In rural counties. Post jobs, does the public understanding. As an entity, limited how they advertise and opportunities, what they have to offer, connecting grads, opportunity to build connections between worlds, come into public health, build.
- Done a lot to reach out to community, be in conversation, try to implement what they are seeing. Marketing and outreach piece as an ISNT. Wish there were explainers out there to point students to. Robust and legitimate field to ender, different health fields, all of those things explained, so school didn't have to tackle.
- Rural health side, challenge to rural people and keep them in jobs, pay, location, when they do get someone, no housing. How to get them established? How do you share their career ladder pathway? Most information about job opportunities around health, specific to medical, have never heard about public health. To keep people in here,

train them, get them education, help them build career. From community health workers, local will know the best.
- Completely agree, not knowing public health, opportunity to reach pops in high school show them what public health is, rural areas having difficulties with recurring. Students with internship opportunities, great partners, housing is an issue, finding ways to strength partnerships, find resources. Helping people stay in communities. Giving back in public health. More paid internship opportunities in underserved areas.
- Summarize: Uniquely help design education and training programs. Provide students to jobs. Community colleges. Stating the solutions that are out there.

2. What specific resources, support, or changes are needed to strengthen our public health workforce and improve public health outcomes?

- High level change – Building connections was commonly cited as a solution to the challenges facing the public health workforce. Respondents were excited by the idea of being more connected, leaving their "silos". The educators especially wanted to work with the public agencies. There was a desire to connect students to public health, to guide them into a career. Connecting workers to career advancement was also cited, respondents wanted works to continue going up the "career ladder" and not become stuck or leave the filed.
- Invite students – Respondents felt more could be done 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.
- Paid Training – Respondents identified paid training opportunities, internships, placements, etc., as an important resource to address challenges. Included incentives for continuing education for mid-career workers.
- Sustainable funding – More funding across the board. Changes to funding so it is more predictable and constant than how current grants operate.
- Flexibility – Respondents expressed a desire for increased flexibility in hiring requirements for public health workers. Grants can be rigid in who can provide services. There was interest in changes so that diverse levels of providers would be able to do more. Respondents felt that local community health workers could be empowered with the level of credentialing they had, so rural communities would not need to

attract outside workers and could rely on health workers who already knew the area.

Other:

- 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 (mentor, preceptor) who cares about them.
- 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.
- 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.

9/16/2024 – Engagement Session for Academic Public Health Workforce

- Students finding inconsistencies between LPHAs different practices and policies, systems
- From a rural perspective resources – differences with funding and informs the types of public health programs they have as well.
- 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.
- Siloes – decision makers, county commissioners as well
- Within the realm of training and rural – training CHWs, through funds from OHA and federal grant. There is not a broad option of online only courses. If someone lives in Hermiston and wants to get an MPH they can't complete an MPH. They aren't going to 'divorce' their life to get a degree. Tech exists, the paradigm of a professor, the professors aren't willing to utilize the technology.
- TRIO SSS Program – students not aware of opportunities in the public health field, PSU working on this. One fully online program which is an MPH in public health practice
- CHWs – can bill Medicaid, but the OHSU-Office of Rural Health sponsored (NEON-fully online training and OSU, is only offered in rural areas) can't be offered in urban areas.
- Community colleges – (PCC) can create new programming to give students credit in certificate trainings – peer support pr credits could transfer to PSU
- Who could be a convener of Academic Public Health Workforce?
- Could Oregon Public Health Association (OPHA) be a convener for academic public health workforce? Could there be a panel.
- Could Coalition of Local Health Officials in this this discussion.
- Need: Academic Institutions need to provide an online education. Address equitable access.
- Need: Undergrad and Grad PH programs to have at least one class about how a public health department works.
- Need: To promote the field of public health with students.
- Need: Certificate programs for entry level positions in the field of public health
- Need: Communities of practice for collaboration across the academic landscape, shared ideas for curriculum and meeting needs for public health workforce.
- The shared feedback is pretty spot on from Willamette's perspective (cosigned from OSU)- getting everyone on the same page is hard. The

work itself is so interdisciplinary and that isn't always reflected in actual PH programs/actions
- Getting people placed and having them be engaged is really key, and also difficult. Getting folks out to remote areas where there is more need or use for their skills or hopes - but supportive areas of their internships or placements aren't there and leave gaps.
- Training to qualify for positions - like EPH work. The work experience or qualifications don't match the certification requirements (i.e. experience is required to apply for or sit for certification). More jobs that are paid that get folks the training they need so they can then promote, develop, and retain certified professionals
- What qualifies as "experience" is something to be up for match - i.e. we have practice differences between counties, state, local requirements etc. Really committing to the inclusion of lived experience across the spectrum. How we map training, soft/hard skills, lived experience, etc.
- Inclusion of interdisciplinary focuses in practice, not just in words or written. Getting things integrated into HR and practice.
- Timing - getting everyone into internships, opportunities, etc. with the timing of need and activities - needing to pay, advertise, have shared platforming so students and schools can match. Not creating one offs but to create more sustainability and longevity - ala PHAP etc. - codified at the state or collective level -
- paid internships - that is a health equity issue and unpaid, un-stipend, low/un-resourced cannot continue sustainably
- How do we include and integrate returning professionals and non-traditional students into these things like internships and job hunting etc. - how do we honor the experience and life differences of both.
- How do we make these things explicit and tie them to concrete asks - specifics are needed
- Creating collective opportunities for academic partners and state/local partners so that there is shared space. aligning calendars etc.
- How do we partner together to share gaps, opportunities, etc. across governmental public health and CBOs -
- Communication - what does this mean? We hear this constantly, especially following COVID-19 but the resources are limited in the academic space but like with many things we (ap's) need specifics on what this means - is it just for students, is it between orgs, or is it everything and what specifically would be the gaps are addressing.

- Adults want to enter PH workforce or go back to school. Lots of resources through high school and young folks but not a lot for adults who have different needs for housing, childcare, etc.
- Credentials don't emigrate with folks. There's a program within IRCO that helps folks obtain nursing credentials here. Don't see that a lot mirrored in public health systems or spaces.
- They don't educate you on the emotional and cultural aspects of the workforce. How do I protect myself and others? What do systems of care look like? how do you talk to people? How to engage with people? How to navigate systems out of public health that your work would include?

- How are systems paying them? Are Incentivized to even do this work when they could work at Walmart because it's easier and pays close to the same?

- Students should learn about Medicare /medicare that part of everyday life. Students at PSU don't know what a CCO or Medicaid is or how they operate. They need these tools to be able to help the communities they are serving.

Tribal Public Health Workforce

8/28/2024 - Tribal Public Health Modernization All Grantees Meeting

What are your public health workforce needs?

1. 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)
2. 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

   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.
3. Would like investments in "Grow your own" – fast track/college, training local tribal community to carryout the functions needed for public health.

9/13/2024 - OHA Tribal Leaders Monthly Meeting

Do the themes from PHM Tribal staff feedback resonate from your perspective? If so, how?

For the most part, yes.

Homegrown Approaches:

- Would like to do more to 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.
- Outside professionals are hired for public health jobs and then invested in for training and certifications and then leave. This is a big challenge. Non tribal folks are often the ones that leave - feels exploitive

Pay

- Losing people to county government, pay is better.
- Competitive salaries and benefits.

Burnout/Workload:

- Pay, stress, infrastructure, support...it's rough, even for tribal members. If you work for a tribe, you're going to be doing "other duties as assigned."
- It is very stressful, a lot of needs in a tribal community so, unless you really love the people, you are liable to burn out and that happens even if you are from that tribes.

Workforce Support:

- Getting the money but then actually getting the rubber to meet the road in terms of hiring and doing the work
- Providing housing.
- Recruitment and retention mentioned, housing for professionals.
- Desperate to keep people - provide training but then folks leave. Need better mechanisms to keep people
- Not just training, not just people, but also thinking about areas of support that keep workforces present, happy

Are there other themes or additional feedback that should be added? If so, what?

- Recommend no cost housing for recruitment/retention and contracting instead of a straight hire.
- Sovereign nations have different rules and ways - especially financial etc. - also an issue of retention, etc.
- Continue to share status updates for workforce planning via Danna's role in the OHA TMM.
- OHA-PHD can help with making connections with workforce planning clearer for Tribes, for other PH strategic priorities
    - Navigating Accreditation for tribes going down that path (great having NPAIHB to pull our tribes together to share resources, meet challenges, etc.)
    - PHM Assessment and Work is very successfully moving our programs!
    - SHA and partnership relationship - need to relate things more clearly so that OHA/PHD partnerships are transparent

Public Health Workforce mixed group of workforce categories

8/1/2024 – Public Health Modernization Chat

1. What are the biggest challenges or obstacles preventing our public health workforce from effectively doing their jobs and meeting community needs?

1. Scholarships and recruitments to provide access to these professions
2. Filling positions in Coos Bay due to housing availability. This includes neighboring cities like Bandon, Florence, Eugene
3. Attracting workers into a community that is both a viable place to both live and work
4. Need more sponsors for public health CHW, Doula, THW training.
5. 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
6. Doulas/community workers are the people who can help. Trainees need to get to them. Need to make curriculum designed specifically for Latino people, culturally sensitive
7. All trainings are in English and they are expensive for Latino communities.
8. We need more sponsors to spread these trainings
9. 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
10. 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
11. Starting to partner with CCOs for funding. Hopefully get the dollars out the door in different ways. Hoping to make connections for more opportunities.
12. 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 workforce.
13. Sometimes we have to reject doula candidates because they don't have social security (which impedes them from being hired by hospitals)

2. What specific resources, support, or changes are needed to strengthen our public health workforce and improve public health outcomes?

- Doula trainings – scholarships from Clackamas County, Legacy Health, etc.
- Sponsorships and scholarships for workforce development
- Want equity policies to be applied in a good way
- OHA DOES 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.

PHAB Workforce Engagement Feedback Collection

	Submission Reviewed	Date Submitted	Workforce Identity or Representation	Workforce - Other
1	☑	09/16/24 2:04 PM	Academic & Educational Partner	
2	☑	09/16/24 1:58 PM	Academic & Educational Partner	
3	☑	09/11/24 7:09 PM	Community Based Organization	
4	☑	09/11/24 10:29 AM	LPHAs	
5	☑	09/03/24 7:01 AM	Tribal Health Partner	
6	☑	08/26/24 12:35 PM	Other	I was surprised that I didn't see PSW, HCW or PCA listed as healthcare workforce.
7	☑	08/26/24 10:10 AM	Community Based Organization	
8	☑	08/23/24 5:54 PM	Community Based Organization	

Workforce Challenges/Obstacles	Workforce Resources, Supports, or Changes
Public skepticism or ambivalence about PH; lack of clarity about cost-effectiveness of upstream interventions; underfunding of programs but also general salary levels fro intro on up; lack of scholarships and subsidies to complete education incl MPH	Fund internships and template county health and local NGO relationships with academic institutions with PH programs so that students who may potentially enter the PH workforce after grad (and/or further training) can accrue experience and witness and appreciate the work being done; existing PH academic programs can offer trainings, badges, certificates etc to the existing workforce lacking adequate PH educational training in G and NG settings
Barriers for folk who are parts of those communities to get trained and work in public health, and then work through the system to be decision-makers.	Push more explicitly against capitalism and white supremacy.
	Eliminate governmental barriers, so people feel more welcome and comfortable with application for existing services,share the power with more specific,culturally and linguistic.
Stable, flexible funding.	
Additional support from tribal leadership regarding the work that we are performing and its potential impact. Communication with local organizations to partner together and work towards the same goals. The tribal organizations that fall within these communities are working at the same challenges.	Collaborative meetings with local and state public health departments, to help identify the need for the community or area served and improve the utilization of community resources.
There is significant barriers for people with disabilities, including aging adults and children and adults with intellectual and developmental disabilities to find in-home care workers. The workforce shortage is significant and disproportionately effects people living in more rural parts of Oregon. People are going without services and basic needs being met. It is critical to address this urgent matter in a more cross-system efficient way. We need one title instead of three! The would eliminate the backlog of background checks needed too. Currently, people have to apply in seperate systems to be a PSW (DD Services) HCW (APD services) PCA (Mental/Behavioral health). It is a mess!	The Oregon Home Care Commission and OHA should work together to address the workforce shortage as a whole and not addressed in silos as it currently is. Please connect with me for more information: jheidrick@thearcoregon.org Thanks for this opportunity to share and advocate.
The community my organization serves are low income and many are immigrants or their parents are immigrants and are not native English speakers. My program educates about climate change, associated health impacts, and prepares for those impacts and climate emergencies. This community has economic and social burdens, so polluted air and a rapidly changing climate adds to that burden. There is only so much they can do to take care of themselves. It will take big policy decisions to reduce air pollution, wildfire smoke, heat waves and power outages in winter. They also tend to be renters and most programs at the state for addressing these climate impacts are for home owners. Not many low income people own their home, so these programs don't help them much.	Opportunity to further educate legislators about how our environment affects and shapes our health daily and long term, how existing programs are not effective for renters who cannot control the physical building in which they live. Incentives for landlords/property owners to make their buildings more climate resilient and safe/healthy for renters.
We simply need funding for the wages and fringe benefits to implement the work. We are particularly in need of a marketing specialist to help publicize our work effectively.	We are particularly in need of a marketing specialist to help publicize our work effectively and stipend to contract Spanish speaking translators.

Related Foundational Capability	Reviewer Notes/Comments
Community Partnership Development Emergency Preparedness and Response Health Equity and Cultural Responsiveness Policy and Planning	
Health Equity and Cultural Responsiveness Leadership and Organizational Competencies	
Community Partnership Development Health Equity and Cultural Responsiveness Leadership and Organizational Competencies	
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Community Partnership Development Policy and Planning	

	Submission Reviewed	Date Submitted	Workforce Identity or Representation	Workforce - Other
9	☑	08/23/24 4:07 PM	Community Based Organization	
10	☑	08/23/24 1:46 PM	OHA - PHD	
11	☑	08/21/24 4:07 PM	OHA - PHD	
12	☑	08/08/24 10:58 AM	LPHAs OHA - PHD	
13	☑	08/05/24 3:15 PM	LPHAs	

Workforce Challenges/Obstacles	Workforce Resources, Supports, or Changes
Short funding of position. Just when work starts and people begin seeing the benefits of a program, funding will end and that program ends.	We need to have long time funding for programs that support unserved communities. while giving out incentives is not favored by most organizations, you should all know that part of the problem that most people deal with is illness and poverty. Coming out for events helps with depression, and that good for nothing $50 that is seen as a big deal for funders can make a difference in a family's life. This is not a way for government to share money, but we need to understand our communities and the cultures and things that can help strengthen their health outcomes. Rich people making decisions about funding do not understand poverty or what it means to live in poverty. They only understand the capitalist ideas and not the reality of the people outside their cycle. If we want to see changes in public health workforce, you have to employ people who have lived experience to be in the four fronts of policies and decision making. Two years ground will not provide CBO enough time to serve the community. they will only start and stop programs, and the benefit will not be felt or make much impact in the society. How can health outcome be improved when the same agencies/system that is charge with improving it is also at the center of creating the problem. my answer to this question is for OHA to look inward and be realistic about what they represent.
Lack of internal management and accountability to keep workstreams moving forwards; lack of internal collaboration leading to redundancies, confusion, and a diffusion of responsibility between state partners	Internal accountability metrics with consequences
Coordination, communication and clear organization esp. vis a vis who does what, who to ask, etc. This last is true both within OHA and, from what I hear, in how LPHA and CBO partners interact with OHA.	At least as we lean into what modernization will look like, it would be very helpful to have a few strategically placed wayfinding helpers who have a clear understanding and vision who can keep us oriented as we go AND serve as points of contact for LPHA/CBO partners.
Ineffective systems, inadequately trained workforce and not having the resources (specifically the software, hardware, and number of staff) we need to meet our individual and organizational goals, including deliverables.	Even when we have the budget, we are unable to hire staff or get position authority to hire staff in a timely way to complete a project. It's not uncommon to get position authority granted 18-months into a 2-year grant - clearly we would not hire someone just in time for the grant to be over. We also struggle with purchasing and maintaining necessary software; for example, we spent over 18-months and countless hours trying to justify the business case to get the analytic software we needed to complete a project for the legislature. The project was over and the report was written by the time we received approval and then still could not get OIS to support installation and troubleshooting since it was an exception. We had to learn to do it ourselves and the software still does not function correctly. The public health workforce is exhausted jumping so many bureaucratic hurdles in a workweek when all we are doing is trying to do our jobs.
I think the biggest challenge is just having enough resource - funding and person-power. Being relatively new to the LPHA, I see that workers have had a lot on their plates. Knowing/discovering which interventions will be most impactful (from a community health standpoint) would help individuals prioritize their work so that they don't feel like they need to do it all.	I think leadership training (for front-line managers/supervisors) is needed; this is particularly relevant for folks who don't come with a PH background. I also think training for front-line PH workforce in collaborating with evaluators. One thing I have noticed in MCHD, is that many of my co-workers come from very diverse professional backgrounds - this is an asset, but there is a lack of understanding of how to incorporate evaluation to improve programming.

Related Foundational Capability	Reviewer Notes/Comments
Community Partnership Development Health Equity and Cultural Responsiveness Leadership and Organizational Competencies Policy and Planning	
Communication Community Partnership Development Leadership and Organizational Competencies	
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