Building a Sustainable Governmental Public Health Workforce to Truly Support Local Communities

In light of the multitude of discussions, proposals, and federal dollars related to the governmental public health workforce, on behalf of our nation's local governmental public health departments, below are high level principles and recommendations related to how best to build the public health workforce we need. The National Association of County and City Health Officials (NACCHO) and the Big Cities Health Coalition (BCHC) represent the nation's nearly 3,000 local health departments, and 30 of the country's largest, most urban departments, respectively. Our members have not only been on the frontlines of the pandemic response for the past year but have also experienced firsthand the field's workforce challenges for many years.

We very much appreciate the increasing focus on the public health workforce and believe it is critically important to "get it right" this time. To do so, a strong emphasis on strengthening local health department capacity is necessary to meet our national public health goals for the pandemic and beyond. Unfortunately, our governmental public health workforce was in a crisis before the COVID-19 pandemic. Local health departments entered the pandemic down over 20 percent of their workforce capacity compared to before the 2008 recession – and we do not yet know what the longer-term workforce implications of the pandemic will be.[1] Over the same period, the nation's population increased by 8 percent,[2] with the number of full-time equivalent employees dropping from 5.2 per 10,000 people to 4.1 per 10,000 people in 2019.[1] At the same time, public health challenges have increased. Impending retirements, staff that do not reflect the demographics of their communities, and positions tied only to specific ailments/funding streams have led to both a shortage in people power and a lack of flexibility to meet new challenges.

It is also important to note that the local health department response to the pandemic has had wide-reaching implications for its attention to, and provision of, services beyond the pandemic. Preliminary findings from NACCHO's 2020 Forces of Change survey show that 80.5 percent of local health departments reassigned existing staff from their regular duties to the agency's COVID-19 response. In situations where staff were reassigned, 72.9 percent of LHDs reported that employees performed fewer of their regular duties, and nearly half (46.6%) indicated their regular duties were not performed at all. The programmatic areas most impacted by service reduction include Obesity prevention (74.7%); Maternal and child health services (60.1%); Tobacco, alcohol or other drug prevention (64.6%); and screening activities for blood lead (58.8%), high blood pressure (63.0%), and diabetes (66.0%). This highlights the importance of strong staffing levels not just to respond to the pandemic, but also to rebuild the many other health department priorities that have been impacted by the response.

As we think about how best to build back better, both responding to the current COVID-19 pandemic and preventing the next one, we need a modern, well-resourced, and sustainable public health workforce that has the right mix of skills, and one that is made to last. The pandemic and the increased attention paid to public health can allow us to look forward, use what we have learned over the past year, and create a truly robust all-hazards public health infrastructure that is able to rapidly and effectively address public health issues that may arise, no matter what the epidemic or situation, as well as work day in and day out, to prevent death and disease and build healthier, more resilient communities.

Relevant Federal Directives

Executive Order 13996 of Jan 21, 2021, "Establish the COVID-19 Pandemic Testing Board and Ensure a Sustainable Public Health Workforce for COVID-19 and Other Biological Threats," Sec. 4. Establishing a Public Health Workforce Program includes:

- The Secretary of Health and Human Services (HHS) will submit to the President a plan detailing
  - How he would deploy personnel in response to future high-consequence public health threats;
  - Five-year targets and budget requirements for achieving a sustainable public health workforce, as well as options for expanding HHS capacity, such as by expanding the U.S. Public Health Service Commissioned Corps and Epidemic Intelligence Service, so that the Department can better respond to future pandemics and other biological threats.

- The Secretaries of HHS, Homeland Security, Education, Labor and others shall submit a plan to the President for establishing a national contact tracing and COVID-19 public health workforce program, to be known as the U.S. Public Health Job Corps, which shall be modeled on or developed as a component of the FEMA Corps program. The U.S. Public Health Job Corps will:
  - Conduct and train individuals in contact tracing related to the COVID-19 pandemic;
  - Assist in outreach for vaccination efforts, including by administering vaccination clinics;
  - Assist with training programs for State, local, Tribal, and territorial governments to provide testing, including in schools; and
  - Provide other necessary services to Americans affected by the COVID-19 pandemic.

American Rescue Plan Act of 2021, passed by the U.S. Congress and signed into law by President Biden, provides $7.6 billion to carry out activities related to establishing, expanding, and sustaining a public health workforce, including by making awards to State, local, and territorial public health departments.

Recommendations for How Best to Rebuild the Public Health Workforce

Below are recommendations to consider in deploying resources and implementing next steps related to the Executive Order 13996, the American Rescue Plan (ARP), and other similar workforce proposals.

- *Build, Support, and Maintain the Existing Workforce*

  We need to invest in a long term, well-funded, well trained, and diverse public health workforce that is reflective of the community and employed by, or detailed long term to, local health departments. This will take sustained and predictable federal funding to create and support jobs that can support core public health functions, work across health department programs (as opposed to being tied exclusively to siloed disease-specific programs), and support the foundational capabilities of health departments so that all Americans can benefit from these efforts no matter where they live.

  It also requires efforts to recruit and retain top talent, whose skillsets are in even higher demand since the beginning of the pandemic. Our organizations support the establishment of a public health loan repayment program, as introduced in the 116th Congress by Representatives Crow (D-CO) and Burgess (R-TX) and Senator Tina Smith (D-MN). Modelled after the National Health Service Corps, this program could be one way to incentivize governmental public health careers and bring needed skillsets to health departments across the country.

  While we work to increase staffing and capacity at public health departments, we must also look to increase salaries and increase benefits to make these positions more competitive and offer those already in the pipeline a career ladder to stay in the field.

- *Ensure Balance and Coordination Across Short- and Long-term Staffing Schemes To Build a Sustainable Public Health Workforce*

  While we appreciate the interest in creative approaches to address governmental public health workforce challenges, we caution that while a U.S. Public Health Jobs Corps could contribute to some surge staffing capacity, it is not a substitute for building a sustainable public health workforce. Similarly, an influx of untrained workers that depends on a national service model, which often reflects only those who can afford to volunteer their time, is not a sufficient workforce strategy to address both every day challenges and large-scale emergencies.

  Further, increases in the workforce aimed at the COVID-19 response, including a Public Health Corps program, should operate inside existing public health response planning. In addition, volunteers should be leveraged through existing or newly formed Medical Reserve Corp Units, who already serve this function and donated over 800,000 hours to the response in 2020. For long term sustainability, strengthening and growing those entities—along with investments in the more formal workforce--is critical.

  There is also need for well-trained paraprofessionals, logistics, and administrative staff, not just those with full public health professional training; however, a national service model will not fill the roles needed to address challenges like COVID-19 or the many public health needs of the community between large-scale crises.

- *Consult with Local Health Leaders and Engage with Existing Public Health Workforce*

  Health departments across our membership have different needs and must be engaged in conversations at the outset about how best to resource their communities in the ongoing response, and recovery from, the COVID-19 pandemic. EO 13996 specifically requires "the Secretary of HHS and the Secretary of Labor [to] promptly ***consult*** with State, local, Tribal, and territorial leaders to understand the challenges they face in pandemic response efforts, including challenges recruiting and training sufficient personnel to ensure adequate and equitable community-based testing, and testing in schools and high-risk settings."

  The nation's local health departments operate under a variety of governance structures, the majority of which are "home rule" and are independent governing units from the state health department. As such, direct local input must be actively sought and included from a wide range of local health department stakeholders, representing the experience of the local public health workforce, regardless of geographic location or department size. The voice of our members, who are on the ground working with and among their communities every day, is vital in planning and implementing comprehensive workforce strategies.

- *Resources, Both People and Dollars, Must Get to the Ground Level Quickly*

  Ensuring that resources get to the local level in an efficient and timely manner is incredibly important and all-too-often overlooked. Local health departments are the front line and, in their communities in particular, the face of the governmental public health enterprise. However, traditionally most CDC funding mechanisms place them at the end of the line for possible resources, often without meaningful inclusion to ensure sufficient funds are made available in a timely manner.

  While we urge the federal government to enable as many communities as possible to receive funds directly (automatically or via application), where that is not possible, there needs to be guidance to states with specific language *and instruction* requiring that local health departments receive an appropriate portion of the funds in a timely manner without additional requirements beyond the federal guidelines. In the past, despite federally allocated funds for local response, state channeled funds have been slow to arrive to the local health departments, which can significantly impact their ability to hire and train needed staff. Ideally, local health departments, not just states, should be able to request these resources and staff from federal agencies and partners.

  Finally, the US Office of Management and Budget (OMB) and/or HHS must ensure that federal funds are publicly tracked, including information about how much has been sent by states to the local level and the timeframe for receipt to both identify best practices as well as better understand the historical challenges of getting money to the front lines.

- *Federal Funding Must be Sustained and Predictable*

  The "boom and bust" cycle on which we fund the public health system is not conducive to sustainability, particularly in public health preparedness, and will not build back the lasting capacity needed to protect and promote the public health's health. This has proven to be painfully evident in our country's pandemic response to date.

Funds must be predictable and sustained so that health departments can plan for and hire the staffing they need on a "permanent" basis, not based on the lifetime of a grant, which could be a year, for example. In these instances, staff are hired and trained by local health departments, but not retained for the long term.

We also must ensure that these funds get to the core needs of local health departments, which includes, but is not limited to, public health preparedness. For example, health departments' critical work on preventing chronic disease cannot be separated from the pandemic as these diseases have been shown to be a dangerous pre-existing condition for COVID (and so many other costly outcomes). Similarly, the pandemic has highlighted the need to also support LHD staff, and the community as a whole, to continue to address health disparities and build a more equitable health system for all.

- *Mechanisms for Local Support*

  Creative funding mechanisms that have invested both dollars and people in the community largely on behalf of local health departments who do not receive resources directly (or in times of emergency so that hiring doesn't need to happen on a local government timeline) have proved an amazing tool in supporting on-the-ground needs. The CDC Foundation, for example, has rapidly hired qualified applicants to work in local health departments, as well as purchased resources on their behalf, throughout both the pandemic response and to address the opioid crisis. Other non-governmental partners could also serve as "fiscal agents" to support rapid intake and output of resources. Partnering with community-based organizations, for example, that have relationships both with health departments and specific populations they serve, could both sped up processes and could be critical in distributing vaccine, for example.

  We also need to have flexible approaches to help local health departments hire directly. A variety of options should be employed depending on what works for the individual health department: staff may be employed by the health department, long-term embedded staff (that can be directly requested from the federal government by a local agency), or allowing small health departments to come together to hire shared professionals that they may not be able to afford alone, such as an epidemiologist or informatician.

- *Leverage Existing Infrastructure at Health Departments and Across Workforce Programs*

  While not a substitute for permanent workforce employed at the local level, workforce programs based at the CDC, such as the Public Health Associate Program (PHAP) and the Epidemic Intelligence Service (EIS), as well as other detailed federal employees, have been used in this crisis (and before) to extend the capacity of health departments and key partners at all levels of government. This should continue, and the PHAP and EIS programs should be expanded. They provide critical capacity and public health know-how to supplement the current workforce, and many "graduates" of these programs control their careers in governmental public health. Unfortunately, low pay often makes it difficult for these trainees to join their health department after their traineeship has ended. Additional consideration should be given to efforts to help those individuals continue their career in local public health departments.

  Where utilized, staffing placements and/or detailees, including federal employees, should be integrated within the health department to which they are detailed, to maximize effective functioning and promote connection and collaboration with existing public health prevention and response efforts.

For any staff details, placements, or deployments, it is critical that local health departments be able to request these staff directly from the federal programs. Moreover, outreach should be conducted to help lower resourced health departments apply so that they can be competitive for this important assistance.

- *Diversify the Workforce to Reflect the Community*

  Reflecting the community being served is important "to ensure that they create trust and are as effective as possible." All public health workforce programs should consider how to best support efforts to increase diversity, open doors of opportunity for all, and make every effort to ensure that the individuals responding to public health crises represent those affected by the crisis. The growth and retention of the public health workforce should contain a specific focus on racial and ethnic diversity to address issues of trust, confidence, and representation of the diversity of the residents served by the health department.

- *Priority Governmental Public Health Workforce Positions and Functions*

  Key workforce positions most in need by local health departments essential for COVID response (and beyond) include informaticians, molecular lab specialists, public health nurses, and epidemiologists, as well as policy, outreach, communications, and administrative support. The latter, which includes legal, human resource, and finance and contract management positions are often excluded from federal grant mechanisms and are an integral part of ensuring that the work can done in communities across the country.

  While highlighting specific occupations is helpful to show the range of positions needed, it is also important to ensure flexibility so that health departments can staff up not just based on title but based on functions and skillsets. This is particularly important for smaller health departments where individual staff must fill numerous roles.

  Sustainability and flexibility in the use of workforce funds is critical to build legitimate capacity in governmental public health. While we must hire positions now that can respond to COVID-19, we must also shift to preparing for future public health emergencies, building a trained, ready, workforce.

We look forward to working with the Biden Administration and the U.S. Congress in implementing this important and historic investment in the nation's public health workforce. We have an opportunity to truly build back better while making meaningful impact in the health and safety of our nation. Please do not hesitate to reach out to either Chrissie Juliano, Executive Director, BCHC (juliano@bigcitieshealth.org) or Adriane Casalotti, Chief of Public and Government Affairs, NACCHO (acasalotti@naccho.org) to discuss these recommendations in more detail.

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[1] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. Retrieved October 30, 2020 from https://www.naccho.org/uploads/downloadable-resources/2019-ProfileWorkforce-and-Finance-Capacity_final-May-2020.pdf

[2] Population Reference Bureau, The U.S. Population Is Growing at the Slowest Rate Since the 1930s, https://www.prb.org/the-u-s-population-is-growing-at-the-slowest-rate-since-the-1930s/