The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice

Conference Call Meeting

~

Thursday, July 28, 2011
12:30-2:30 pm ET

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Call Number: 1.888.387.8686
Passcode: 8164961

Funding provided by the Centers for Disease Control and Prevention and the Health Resources and Services Administration

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Staffed by the Public Health Foundation

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1. Meeting Agenda

The Council on Linkages Between Academia and Public Health Practice

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Conference Call Meeting
Date: **Thursday, July 28, 2011**
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AGENDA

12:30 pm—12:35 pm	Welcome and Overview of Agenda	*Bill Keck*
12:35 pm—12:40 pm	Introduction of New Council Members ➢ Melissa Alperin (ASPH) ➢ Louis Rowitz (NLN)	*Bill Keck*
12:40 pm—12:45 pm	Approval of Minutes from March 29, 2011 Meeting	*Bill Keck*
12:45 pm—1:00 pm	HRSA Recruiting	*Janet Heinrich*
1:00 pm—1:05 pm	Council Chair Election Results	*Ron Bialek*
1:05 pm—1:20 pm	Status of Council Funding ➢ CDC ➢ HRSA	 *Denise Koo* *Wendy Braund*
1:20 pm—1:40 pm	New Strategic Directions for 2011-2015 ➢ Council Administrative Priorities ➢ Comments from Council members	*Bill Keck* *Ron Bialek*
1:40 pm—1:50 pm	Academic Health Department Learning Community Report ➢ Status of initiative ➢ Next steps	*Bill Keck*
1:50 pm—2:00 pm	Core Competencies Workgroup Report ➢ Status of tools initiative ➢ Action Item: Recommendation to combine Workgroup and Subgroup ➢ Upcoming presentations at national meetings	*Diane Downing* *Janet Place*

2:00 pm—2:10 pm	Pipeline Workgroup Report ➢ Exploring new directions – public health workforce and the Affordable Care Act ➢ Next steps	*Vince Francisco* *Bill Keck*
2:10 pm—2:20 pm	Training Impact Task Force Report ➢ Status of initiative ➢ Next steps	*Wendy Braund*
2:20 pm—2:25 pm	Other Business	
2:25 pm—2:30 pm	Next Steps	
2:30 pm	Adjourn	

2. Council Member List

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Members

Council Chair:

C. William Keck, MD, MPH
American Public Health Association

Council Members:

Hugh Tilson, MD, DrPH
American College of Preventive Medicine

Wendy Braund, MD, MPH, MSEd
Health Resources and Services Administration

Amy Lee, MD, MBA, MPH
Association for Prevention Teaching and Research

Larry Jones, MA, MPH
National Association of County and City Health Officials

Gary Gilmore, MPH, PhD, CHES
Association of Accredited Public Health Programs

John Gwinn, PhD, MS, MPH
National Association of Local Boards of Health

Jack DeBoy, DrPH
Association of Public Health Laboratories

Chuck Higgins, MSEH, REHS
National Environmental Health Association

Melissa Alperin, MPH
Association of Schools of Public Health

Lisa Lang, MPP
National Library of Medicine

Terry Dwelle, MD, MPH
Association of State and Territorial Health Officials

Julia Heany, PhD
National Network of Public Health Institutes

Christopher Atchison, MPA
Association of University Programs in Health Administration

Louis Rowitz, PhD
National Public Health Leadership Development Network

Denise Koo, MD, MPH
Centers for Disease Control and Prevention

Jeanne Matthews, PhD, RN
Quad Council of Public Health Nursing Organizations

Diane Downing, PhD, RN
Community-Campus Partnerships for Health

Vincent Francisco, PhD
Society for Public Health Education

3. Council Constitution and Bylaws

Council on Linkages Between Academia and Public Health Practice

Constitution and Bylaws

ARTICLE I. – MISSION:

The mission of the Council on Linkages Between Academia and Public Health Practice (Council) is to improve public health practice and education by fostering, coordinating, and monitoring links between academia and the public health and healthcare community, developing and advancing innovative strategies to build and strengthen public health infrastructure, and creating a process for continuing public health education throughout one's career.

ARTICLE II. – BACKGROUND AND PURPOSE:

In order to bridge the perceived gap between the academic and practice communities that was documented in the 1988 Institute of Medicine report, *The Future of Public Health*, the Public Health Faculty/Agency Forum was established in 1990.

After nearly two years of deliberations and a public comment period, the Forum released its final report entitled, *The Public Health Faculty/Agency Forum: Linking Graduate Education and Practice*. The report offers recommendations for: 1) strengthening relationships between public health academicians and public health practitioners in public agencies; 2) improving the teaching, training, and practice of public health; 3) establishing firm practice links between schools of public health and public agencies; and 4) collaborating with others in achieving the nation's Year 2000 health objectives. In addition, the Public Health Faculty/Agency Forum issued a list of "Universal Competencies" to help guide the education and training of public health professionals.

The Council was formed initially to help implement these recommendations and competencies. Over time, the Council's mission and corollary objectives may be amended to best serve the needs of public health's academic and practice communities.

ARTICLE III. – MEMBERSHIP:

A. Member Composition:

The Council is comprised of national public health academic and practice agencies, organizations, and associations that desire to work together to help build academic/practice linkages in public health. Membership on the Council is limited to any agency, organization, or association that:

1. Can demonstrate that agency, organization, or association is national in scope.
2. Is unique and not currently represented by existing Council Member Organizations.
3. Has a mission consistent with the Council's mission and objectives.
4. Is willing to participate as a Preliminary Member Organization on the Council for one year prior to formal membership, at the participating organization's expense.
5. Upon being granted formal membership status, signs the Council's Participation Agreement.

Individuals may not join the Council.

B. Member Organizations:

Council Member Organizations include:

- American College of Preventive Medicine (ACPM)
- American Public Health Association (APHA)
- Association of Schools of Public Health (ASPH)
- Association of State and Territorial Health Officials (ASTHO)
- Association for Prevention Teaching and Research (APTR)
- Association of University Programs in Health Administration (AUPHA)
- Centers for Disease Control and Prevention (CDC)
- Community-Campus Partnerships for Health (CCPH)
- Council of Accredited Masters in Public Health Programs (CAMP)
- Health Resources and Services Administration (HRSA)
- National Association of County and City Health Officials (NACCHO)
- National Association of Local Boards of Health (NALBOH)
- National Environmental Health Association (NEHA)
- National Library of Medicine (NLM)
- National Network of Public Health Institutes (NNPHI) – Preliminary Member Organization
- QUAD Council of Public Health Nursing Organizations
- Society for Public Health Education (SOPHE)

Membership Categories:

An organization must petition the Council to become a member in accordance with the Council's membership policy. If membership is granted, the agency, organization, or association will become a Preliminary Member Organization for the period of one year. At the conclusion of one year as a Preliminary Member Organization, the Council will vote to approve or decline the agency, organization, or association as a Formal Member Organization. If granted formal membership status, the agency, organization, or association will be reimbursed for travel related expenses for future meetings, if funds permit.

I. Preliminary Member Organization Privileges

1. Preliminary Member Organizations may fully participate in all discussions and activities associated with Council meetings at which they are required to attend.
2. Preliminary Member Organizations retain the right to vote at Council meetings during their preliminary term.
3. Preliminary Member Organizations can participate in any and all Council subcommittee/taskforce discussions that they desire to join.
4. Preliminary Member Organizations' names and/or logos will be included in Council resources that depict Member Organizations during the preliminary term.
5. Preliminary Member Organizations will be responsible for all travel related expenses for attending meetings.

II. Formal Member Organization Privileges

1. In accordance with the Council's travel policy and as funding permits, Organizational Representatives (Representatives) from Formal Member Organizations are entitled to reimbursement up to a predetermined amount for airfare, transportation to and from meeting site, and hotel accommodations for Council meeting travel.

2. As funding permits, Representatives from Formal Member Organizations will be reimbursed at the federally-approved per diem rate for meals consumed during travel to and from Council meetings.
3. Substitutes for officially designated Representatives are not eligible for travel reimbursement.
4. Formal Member Organizations retain full participation privileges in all Council discussions, activities, votes, and subcommittee/taskforces.
5. Formal Member Organizations will be represented either via logo or text in all Council resources that depict membership.
6. Formal Member Organizations must comply with the signed Participation Agreement.
7. Representatives from federal government agencies will not receive funding from the Council for travel or related expenses.

ARTICLE IV. – MEMBER ORGANIZATION RESPONSIBILITES:

In order for the Council to meet its goals and corollary objectives, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council membership requires that:

- Each Member Organization (Organization) select an appropriate Representative to serve on the Council for, at a minimum, one year. Organizations are strongly encouraged to select Representatives who can serve for terms of two or more years.
- The Representative have access to and communicate regularly with the Organization's leadership about Council activities.
- The Representative be able to present the perspectives of the Organization during Council meetings.
- The Representative attend and actively participate in scheduled meetings and shall not miss two consecutive meetings during a given year unless the absence is communicated to Council staff and approved by the Chair before the scheduled meeting.
- Each Organization identify a key staff contact who will keep abreast of Council activities via interaction with Council staff, attendance at locally-held meetings, and/or regular contact with the Representative.
- During at least one meeting each year, Representatives present the progress their respective Organizations and members have made toward implementing and sustaining productive academic/practice linkages.
- Each Representative (or staff contact) respond to requests for assistance with writing and compiling Council documents and resources.
- Representatives and Organizations disseminate information on linkage activities using media generally available to the Council’s constituency and specifically to the respective memberships of the Organizations.
- Upon request of the Council Chair, Representatives officially represent the Council at meetings or presentations widely attended by members of the practice and academic public health communities.

- Upon request of the Council Chair, Representatives assist Council staff with identifying and securing funding for projects, advocating Organizational support for specific initiatives, and serving on Council subcommittees.

If a Representative or Organization does not fulfill the above responsibilities, Council staff will first contact the Representative and Organization in writing. If a Representative fails to address the concerns—for example, in the case of chronic absenteeism at Council meetings—the Council chair may request that a new Representative be selected. Then, if a Member Organization consistently fails to perform its responsibilities after a written warning, Council staff will inform that Organization in writing that the full Council will vote on revoking that Organization's membership. If a majority of all Representatives vote to revoke an Organization's membership, that Organization will no longer be considered a part of the Council.

ARTICLE V. – Discussions, Decisions, and Voting:

A. The following overlying principle shall govern decisions within the Council:

Each Member Organization shall have one vote. Only Representatives or officially designated substitutes can vote. To designate a substitute, Member Organizations must provide the name and contact information for that individual to Council staff in advance of the meeting.

B. Discussions & Decisions:

Council meetings will use a modified form of parliamentary procedure where discussions among the Representatives will be informal to assure that adequate consideration is given to a particular issue being discussed by the Council. However, decisions will be formal, using Robert's Rules of Order (recording the precise matters to be considered, the decisions made, and the responsibilities accepted or assigned).

C. Voting:

1. Each Representative shall have one vote. If a Representative is unable to attend a meeting, the Organization may designate a substitute (or Designee) for the meeting. That Designee will have voting privileges for the meeting.
2. **Quorum** is required for a vote to be taken and shall consist of a majority of the Representatives or Designees of all participating groups composing the Council.
3. **Simple Majority** Vote will be required for internal Council administrative, operational, and membership matters (i.e.: Minutes approvals).
4. The Council will seek **Consensus** (Quaker style – No-one blocking consensus) when developing major new directions for the Council (i.e.: moving forward with studying leadership tier of credentialing). No more than one-quarter of Representatives or their Designees can abstain, or the motion will not pass. Representatives will be expected to confer with the leadership of their organizations prior to the meeting to ensure that their votes reflect the Organization's views on the topic.
5. A two-thirds **Super Majority** of all Representatives will be required to vote on accepting or amending this Constitution and Bylaws.

ARTICLE VI. – COUNCIL LEADERSHIP:

One Representative will serve as the Council Chair. The Chair is charged with opening and closing meetings, calling all votes, and working with Council staff to set meeting agendas.

The term of the Chair is two years. There is no limit to the number of terms a Representative can serve as Chair. At the end of each two-year term, another Council Representative and/or the current Chair may nominate him/herself or be nominated for the position of Chair. To be elected Chair requires a majority affirmative vote of Council membership. In the event that there are several nominees and no nominee receives a clear majority of the vote, a runoff will be held among the individuals who received the highest number of votes.

To be eligible to serve as Chair, an individual must:

- have served as a Council Representative for at least two years; and
- have some experience working in public health practice.

ARTICLE VII. – MEETINGS:

The Council shall convene at least one in-person meeting a year. Funds permitting, the Council will convene additional meetings either in-person or via conference call. All meetings are open to the public.

ARTICLE VIII. – COUNCIL STAFF ROLES AND RESPONSBILITIES:

The Council is staffed by the Public Health Foundation. Council staff provide administrative support to the Council and its Organizations and Representatives. This includes, but is not limited to:

1. Planning and convening Council meetings;
2. General Council administration such as drafting meeting minutes, yearly deliverables, progress reports, action plans, etc.;
3. Working with Representatives and their Organizations to secure core and special project funding for Council activities and initiatives; and
4. Officially representing the Council at meetings related to education and practice.

ARTICLE IX. – FUNDING:

Council staff, with approval from the Council Chair, may seek core and special project funding on behalf of the Council in accordance with Council-approved objectives, strategies, and deliverables.

4. Draft Meeting Minutes – March 29, 2011

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages In-Person Meeting
Meeting Minutes - DRAFT
Hyatt Regency at Crystal City
March 29, 2011
8:30 am - 12:00 pm ET

Members Present: C. William Keck, Chris Atchison, Wendy Braund, José Cordero, Jack DeBoy, Vince Francisco, Gary Gilmore, John Gwinn, Julia Heany, Larry Jones, Denise Koo, Lisa Lang

Other Participants Present: Karlene Baddy, Scott Becker, Alex Hart

Staff Present: Ron Bialek, Kathleen Amos, Pamela Saungweme, Lynne Stauff

Agenda Item	Discussion	Action
Welcome, Introductions, and Overview of Agenda	The meeting commenced with a welcome by Council on Linkages Chair C. William Keck, MD, MPH. All present introduced themselves. Dr. Keck reviewed the agenda for the meeting.	
Strategic Planning Meeting Debriefing	Dr. Keck invited feedback from Council members on the strategic planning session held on March 28, 2011. Council members expressed satisfaction with the strategic planning overall, although it was noted that additional time might have been helpful, especially in terms of identifying tactics for achieving the objectives and strategies created. Council Director Ron Bialek, MPP emphasized the value of having a strategic plan as the Council continues to move forward and seek funding to accomplish its objectives.	Staff will compile the notes from the strategic planning session and send to strategic planning facilitator. Council members will receive a processed, organized summary for feedback. Council members will be asked for suggestions on wording, format, and tactics. There will be at least one or two more opportunities for Council members to provide input into the strategic plan.
Approval of Minutes from October 25, 2010 Meeting	A motion was made to approve the minutes as written.	Council members approved the minutes as written.
CDC Update	Denise Koo, MD, MPH of the Centers for Disease Control and Prevention (CDC) provided an update on CDC activities of potential interest to the Council. These included the launch of CDC Learning Connection; use of Affordable Care Act (ACA) funding to support quality improvement; co-sponsorship with the Health Resources and Services Administration (HRSA) of an Institute of Medicine (IOM) panel on integrating primary care and public health; co-sponsorship with HRSA, the Agency for Healthcare Research and Quality, and the National Institutes of Health (NIH) of a joint issue of the American Journal of Public Health and the American Journal of Preventive Medicine	

	on integrating primary care and public health; hosting of a small planning meeting on the public health workforce in May 2011; and collaboration with the Association of Schools of Public Health, Association of American Colleges and Universities, and Association for Prevention Teaching and Research on an undergraduate public health learning outcomes project.	
HRSA Update	Wendy Braund, MD, MPH, MSEd of HRSA provided an update on HRSA activities of potential interest to the Council. These included the appointment of Dr. Sarah Linde-Feucht as HRSA's acting Chief Public Health Officer; co-sponsorship with CDC of a public health workforce enumeration study and the IOM panel on integrating primary care and public health; sponsorship of two additional IOM studies with public health implications; support of the Healthy Weight Collaborative through ACA funding; and grant opportunities related to the Public Health Training Centers and the Health Careers Opportunity Program. Dr. Braund indicated that HRSA is pleased to support the work of the Council, especially highlighting the Council's strategic planning, and hopes to be able to continue doing so.	
Pipeline Workgroup Report	Pipeline Workgroup Chair Vince Francisco, PhD provided background on how the Council became involved in recruitment and retention efforts and the Pipeline Workgroup's role in these efforts. He highlighted accomplishments of the Workgroup, as well as the effects of the economy on positions in public health. Dr. Francisco indicated that the next steps for the Workgroup include expanding the Council's survey on public health workers with support from the Robert Wood Johnson Foundation and assistance from the Association of State and Territorial Health Officials; conducting a literature review to identify potential recruitment and retention strategies; and contributing to the workforce research agenda.	
Core Competencies Workgroup Report	Dr. Keck provided an overview of the purpose of the Core Competencies Workgroup and the current activities of this Workgroup and its Competencies to Practice Toolkit Subgroup. He reviewed the list of tools that are being developed; a Competencies to Practice Toolkit is under development. Dr. Keck thanked Council member organizations for their efforts to promote Core Competencies use and encouraged them to	

	continue this promotion. He reviewed uses of the Core Competencies for public health organizations, users of the Core Competencies, and examples of use from several organizations. Dr. Keck stated that the Core Competencies are a great example of what the Council is capable of accomplishing and the tools developed will be updated based on feedback from the field.	
Academic Health Department Learning Community Report	AHD Workgroup Chair Dr. Keck introduced the AHD Learning Community, providing information on its purpose, development, and accomplishments. He noted that the AHD Workgroup has been established to guide the Learning Community. He invited Council members to follow the initiative's progress through the PHF/Council website, where discussion is occurring on the PHF Pulse Blog and resources are being posted. Dr. Keck expressed excitement at the enthusiasm for the initiative and noted that the Learning Community will host an in-person meeting at the 2011 APHA annual meeting.	Council members were invited to send AHD-related resources to Kathleen Amos.
Improving and Measuring the Impact of Training	Mr. Bialek introduced the topic of improving and measuring the impact of training as a new Council activity. He indicated that a preliminary literature review was conducted to begin identifying themes related to the topic. Mr. Bialek suggested that the Council establish a Task Force of individuals with expertise to help the public health community identify ways to improve and measure the impact of training.	Council members were asked to send suggestions for Task Force members and critical references relevant to improving and measuring the impact of training to Lynne Stauff.
Guide to Community Preventive Services	Mr. Bialek informed the Council that PHF was awarded funding through the ACA to promote the *Guide to Community Preventive Services* (*Community Guide*). One initiative proposed was the creation of the "Public Health Works" series. Mr. Bialek indicated that PHF has been funded to plan this series, but not to implement. He requested the Council's assistance with this initiative in an advisory role. Mr. Bialek indicated that the "Public Health Works" series is planned to focus initially on CDC's winnable battles and is aimed at public health practitioners. He also noted that several organizations, including PHF, are working to collect stories of *Community Guide* use.	
Feedback from Council Member Organizations	Dr. Keck asked Council members for feedback on issues or topics of importance to their organizations that they might like the Council to consider. Chris Atchison, MPA mentioned the NIH focus on translational research and reducing	

	the time between discovery and application to practice and asked whether the Council might have a role to play. Dr. Braund asked whether the Council would like to engage directly and strategically with the Department of Health and Human Services and its departments, as well as meet with HRSA's new Chief Public Health Officer. Dr. Keck asked Council members what strategies they use to engage their leaders and constituents in Council activities. Larry Jones, MA, MPH indicated that the monthly Council Update is useful and can be shared. Dr. Keck asked Council members for feedback on how Council staff can help facilitate communications with the leaders and constituents of their organizations. Mr. Bialek mentioned that he struggles with knowing how and how frequently to interact with the CEOs of Council member organizations. The question was asked whether the Council might consider having a presence at all member organizations' national meetings. Mr. Bialek indicated that Council presence at national meetings is limited by funding, but that Council staff could think more about this idea.	APHL will send contact information for key staff members to Pamela Saungweme.
New Website	Mr. Bialek provided a tour of the new Council website.	
Next Steps	Dr. Keck indicated that Council members could expect to receive further materials related to the strategic plan within the next month and reminded them to provide feedback. The Council's aim is to have a strategic plan in place by summer 2011. The next Council meeting has not been scheduled and future in-person meetings will depend on funding levels.	Council staff will provide Council members with strategic plan materials to review. Council staff will keep Council members informed about future Council meetings.

5. HRSA Recruiting

The Council on Linkages Between Academia and Public Health Practice

HRSA Recruiting

July 28, 2011

The Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), is beginning a process to recruit for high-level public health positions. The Head of BHPr and Associate Administrator for HRSA, Janet Heinrich, DrPH, RN, FAAN, will discuss these positions with the Council on Linkages Between Academia and Public Health Practice (Council). Council member organizations and others leaders within the public health community can be of great assistance by helping HRSA identify exceptional candidates and encouraging these individuals to submit their names for consideration by HRSA. There will be an opportunity to discuss with Dr. Heinrich these positions and other public health opportunities within HRSA.

6. Council Chair Election Results

The Council on Linkages Between Academia and Public Health Practice

Council Chair Election Report

July 28, 2011

Overview

Leadership for the Council on Linkages Between Academia and Public Health Practice (Council) is provided by an elected Chair. The elections process and the requirements for election to this position are detailed in the Council's *Constitution and Bylaws*, Article VI – Council Leadership. According to the *Constitution and Bylaws*, the Council Chair is a Council Representative elected to serve a two year term. There is no limit to the number of terms a Representative can serve in this position. At the end of each two year term, an election is to be held. Council Representatives may nominate themselves or other Representatives for the position of Chair. All Council Representatives who have served a minimum of two years and have worked in public health practice are eligible for election. Each Council Member Organization, through its Representative, has one vote in the election, and the result of the election is determined by a majority affirmative vote.

2011 Election

With the reconstitution of the Council approximately two years ago and the completion of this spring's strategic planning, an election was set for summer 2011. On July 5, 2011, the elections process was begun with a request for nominations for the position of Council Chair. The nominations period concluded July 11, 2011. A single Council Representative was nominated: C. William Keck, MD, MPH, who represents the American Public Health Association. Voting was open from July 14-20, 2011. Dr. Keck was elected Chair of the Council.

7. New Strategic Directions for 2011-2015

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice: Strategic Directions, 2011-2015

Mission

To improve public health practice, education, and research by:

- Fostering, coordinating, and monitoring links among academia and the public health and healthcare community;
- Developing and advancing innovative strategies to build and strengthen public health infrastructure; and
- Creating a process for continuing public health education throughout one's career.

Values

- Teamwork and Collaboration
- Focus on the Future
- People and Partners
- Creativity and Innovation
- Results and Creating Value
- Public Responsibility and Citizenship

Objectives

- Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.
- Enhance public health practice-oriented education and training.
- Support the development of a highly skilled and motivated public health workforce with the competence and tools to succeed.
- Promote and strengthen collaborative research to build the evidence base for public health practice and its continuous improvement.

Objectives, Strategies, & Tactics

Objective A. Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.

Strategy 1: Promote development of collaborations between academic institutions and practice organizations.

Tactics:

a. Increase membership and activities of the Academic Health Department Learning Community.
b. Document and highlight collaboration and its impact through a Linkages Awards program.

Strategy 2: Promote development of collaborations between public health and healthcare professionals and organizations.

Tactics:

a. Identify cross-cutting competencies for public health and primary care.

Adopted: June 9, 2011

b. Expand the Academic Health Department Learning Community to include primary care professionals and organizations.
c. Document and highlight collaboration and its impact through a Linkages Awards program.

Strategy 3: Document exemplary practices in collaboration.

Tactics:

a. Serve as a clearinghouse for evidence regarding successful linkages.
b. Conduct a periodic review of practice-based content in public health education.

Objective B. Enhance public health practice-oriented education and training.

Strategy 1: Develop and support the use of consensus-based competencies relevant to public health practice.

Tactics:

a. Review the Core Competencies for Public Health Professionals every three years for possible revision.
b. Develop and disseminate tools to assist public health professionals to implement and integrate the Core Competencies for Public Health Professionals into practice.
c. Explore with the Pan American Health Organization, the World Health Organization, and the World Bank ways to make the Core Competencies for Public Health Professionals and supporting resources available to the international community.
d. Serve as a data source for Healthy People 2020.

Strategy 2: Encourage ongoing training of public health professionals and capture lessons learned and impact.

Tactics:

a. Explore methods for enhancing and measuring the impact of training.

Strategy 3: Assess the value of public health practitioner certification for ensuring a competent public health workforce.

Strategy 4: Explore uses of technology for facilitating education and training and enhancing collaboration among providers of education and training.

Objective C. Support the development of a highly skilled and motivated public health workforce with the competence and tools to succeed.

Strategy 1: Develop a comprehensive plan for ensuring an effective public health workforce.

Tactics:

a. Develop evidence-supported recruitment and retention strategies for the public health workforce.
b. Use survey methods to gather additional data about public health workers.
c. Join the Public Health Accreditation Board's Public Health Workforce Think Tank to encourage the integration of competencies into accreditation processes.
d. Participate in, facilitate, and/or convene efforts to develop a national strategic and operational plan for public health workforce development and monitor progress.

Strategy 2: Define training and life-long learning needs of the public health workforce, identify gaps in training, and explore mechanisms to address these gaps.

Strategy 3: Provide access to and assistance with using tools to enhance competence.

Tactics:

a. Assist public health professionals with using tools to implement and integrate the Core Competencies for Public Health Professionals into practice.

Strategy 4: Facilitate learning around effective public health practices.

Tactics:

a. Serve as an advisory body for the Guide to Community Preventive Services Public Health Works initiative.

Objective D. Promote and strengthen collaborative research to build the evidence base for public health practice and its continuous improvement.

Strategy 1: Support efforts to refine the Public Health Systems and Services Research agenda.

Tactics:

a. Identify gaps in the development of research that is relevant to practice.
b. Vet the Robert Wood Johnson Foundation workforce research agenda.
c. Conduct an annual scan to determine progress on implementation of the workforce research agenda.

Strategy 2: Support the translation of research into public health practice.

Tactics:

a. Identify means to solicit and disseminate evidence-based practices.

Strategy 3: Encourage the engagement of practice partners in public health research.

Strategy 4: Explore approaches to enhance funding of public health research.

Council on Linkages Administrative Priorities

- **Communication**: Use communication tools effectively to increase access for diverse audiences to Council initiatives and products.
- **Funding**: Secure funding to support Council activities.
- **Governance**: Review governance structure of the Council.
- **Membership**: Explore desirability of and opportunities for Council membership expansion and diversification.
- **Staffing**: Maintain Council staffing and convening role of the Public Health Foundation.
- **Technology**: Explore uses of technology to facilitate Council activities.

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages: Strategic Directions, 2011-2015
Administrative Priorities

July 28, 2011

During the Council on Linkages Between Academia and Public Health Practice (Council) strategic planning, several priorities for effective administration of the Council were identified. The Council Chair and staff have begun planning to address these priorities. The following details our anticipated initial steps.

Communication: Use communication tools effectively to increase access for diverse audiences to Council initiatives and products.

The key priority identified in the area of communication was increasing awareness of and access to Council activities and products. Currently, several communication methods are used to disseminate information about the Council and its products. These include: maintaining the Council website, producing and distributing the Council on Linkages Update, publishing news articles on the PHF website, blogging on the PHF Pulse blog, and participating in national conferences and meetings through presentations and exhibits. We propose four initial steps toward enhancing Council communication activities:

- Maintain use of the communication methods listed above, while exploring opportunities to maximize the impact of these communication channels in reaching our broad public health audience.
- Pilot test the addition of Twitter to our current communication strategies as a way to push out information. The pilot test will involve establishing communication goals, a pilot time period, and ways to measure success. This pilot test will be initiated within the next three months.
- Request assistance from Council Representatives to explore how Council Representatives and Member Organizations can help us enhance Council communication strategies.
- Discuss ways to enhance Council communications during the fall/winter Council meeting.

Funding: Secure funding to support Council activities.

Funding is likely to remain a concern for the Council for the foreseeable future. Securing and maintaining adequate funding levels to advance the work of the Council remains a priority for us.

Governance: Review governance structure of the Council.

Two items were identified in the area of governance: holding regular elections for Council leadership and possible expansion of Council leadership to include an executive committee.

1. *Regular Elections.* According to the Council's *Constitution and Bylaws*, Article VI – Council Leadership, the leadership of the Council consists of an elected Chair. The term of the Chair is two years, and there is no limit to the number of terms a Council Representative can serve in this position. All Council Representatives who have served a minimum of two years and have worked in public health practice are eligible to stand for election. Each Council Member Organization, through its Representative, has one vote in the election, and the result is determined by a majority affirmative vote.[1] Preparation for an election for the Council Chair position has begun. A request for nominations has been distributed. Voting is expected to occur in mid-July, with the winner announced at the July meeting of the Council.
2. *Executive Committee.* The idea of establishing a formal executive committee to assist in governing the Council has been previously considered. Currently, the Chairs of the Council Workgroups and Task Force serve as an informal executive committee that conducts Council business in between Council meetings. The Council Chair monitors the work conducted and reports to the full Council. This arrangement has served the Council well over the years and has enabled flexibility in responding to changing circumstances.

Membership: Explore desirability of and opportunities for Council membership expansion and diversification.

Two priorities under the umbrella of membership have been identified: expansion and engagement.

1. *Council Membership Expansion.* The question of whether expansion of the Council's membership would be desirable has been raised. Some Council members have proposed expanding Council membership, while others have expressed concern over membership growth. We would like to be strategic about any decisions that are made and request that the Council revisit this topic at a future meeting.
2. *Council Member Engagement.* Prior to considering expanding Council membership, we propose to maximize engagement of existing Council members. Each Council Representative is responsible for serving as a communication liaison between the Council and his/her Member Organization and constituency, engaging in the business of the Council at meetings, and contributing to the development of Council resources. Council Representatives have the opportunity to participate more extensively in Council initiatives through involvement with Council workgroups. Building on this foundation, we propose the following initial steps to increase engagement:
    - More clearly communicate to new Council Representatives the activities of the Council and opportunities for involvement.

[1] Council on Linkages Between Academia and Public Health Practice. (2006). Council on Linkages Between Academia and Public Health Practice: Constitution and Bylaws.

- Periodically remind Council Representatives of ongoing activities and opportunities to become involved.
- Actively request Council Representative assistance in communicating Council activities to our broad public health audience through activities such as writing for the PHF Pulse blog.
- Contact all Council Member Organizations to discuss the Council and its future directions. The Council Chair and Director will speak via conference call with the Representative, director/CEO, and staff contact of each Council Member Organization within the next six to nine months.

To assist in accomplishing these initial steps, we will be asking all Council Representatives to provide current professional information, including an updated CV and brief biography, within the next three months.

Staffing: Maintain Council staffing and convening role of the Public Health Foundation.

Staffing of the Council is closely tied to Council funding and, as such, will likely continue to be an area of concern. Maintaining adequate staffing levels to support a productive Council remains a priority for us.

Technology: Explore uses of technology to facilitate Council activities.

Technology priorities center on the use of technology to efficiently conduct Council activities. A key Council activity is communication and the use of technological tools, such as the Council website, the PHF Pulse blog, and Twitter, within communication efforts was discussed above under the priorities for Communication. Many of the communication methods used to disseminate information to the public also serve as means to disseminate information to Council Representatives and Member Organizations. Additionally, we propose to:

- Redesign the Council workgroup pages within our website to become more of a “home” for workgroup activities where all relevant information, such as current activities, resources under development, and upcoming meetings, can be accessed. This redesign will begin within the next three months.
- Request assistance from Council Representatives to help us identify ways to maximize the value obtained from the technologies we currently use and investigate promising new technologies and their potential value for the Council.

We are committed to the continued success of the Council on Linkages Between Academia and Public Health Practice. Feedback and ideas related to administrative issues are welcome from Council members at any time.

8. Academic Health Department Learning Community Report

The Council on Linkages Between Academia and Public Health Practice

Academic Health Department Learning Community Report

July 28, 2011

Overview

The Academic Health Department (AHD) Learning Community is a national community of practitioners, educators, and researchers interested in the use of the AHD model within public health. An AHD is formed by the formal affiliation of a health department and an academic health professions institution and can enhance public health education and training, research, and service. The AHD Learning Community brings public health professionals together to share knowledge and engage in collaborative activities that support the development, maintenance, and expansion of AHDs. The structure and activities of the AHD Learning Community are guided by the AHD Workgroup.

Current Activities

Since its launch earlier this year, participation in the AHD Learning Community has steadily increased. Over 80 public health professionals have joined the Learning Community. The Learning Community has held two conference call meetings to engage members, and a number of Learning Community activities are underway. The Learning Community is working to identify AHDs across the country and to collect and share the agreements that established these partnerships. Building on input received from the Learning Community, a new one page summary of the AHD concept, its benefits, and steps toward beginning AHD development is now available online. This summary complements the previously created AHD concept paper. Preliminary lists of competencies for AHD leaders and of roles and responsibilities for individuals involved in building, sustaining, and growing AHD partnerships are also being crafted.

Meetings

AHD Learning Community meetings will continue to be held by conference call. The next conference call meeting is anticipated to occur in fall 2011. Additionally, the Learning Community will hold its first in-person meeting at the American Public Health Association Annual Meeting this fall in Washington, DC. All Learning Community members and others interested in learning more about AHDs and the Learning Community are invited to join us for the meeting on Tuesday, November 1st from 8:30-10 am.

The Council on Linkages Between Academia and Public Health Practice

AHD Workgroup Members

Chair:

- *C. William Keck*, Department of Community Health Sciences, Northeastern Ohio Universities Colleges of Medicine and Pharmacy

Members:

- *Wanda Aberle*, Retired Health Department Director of Nursing
- *Christopher Atchison*, College of Public Health, University of Iowa
- *Gerald Barron*, Graduate School of Public Health, University of Pittsburgh, PA
- *James Burns*, College of Medicine, Florida State University; Sacred Heart Children's Hospital, FL
- *Marita Chilton*, National Association of Local Boards of Health
- *Larry Cohen*, Centers for Disease Control and Prevention
- *Ralph Cordell*, Centers for Disease Control and Prevention
- *John DeBoy*, Semi-Retired Public Health Laboratory Scientist; Retired Public Health Laboratory Director
- *Diane Downing*, School of Nursing and Health Studies, Georgetown University, DC
- *Patricia Drehobl*, Centers for Disease Control and Prevention
- *Terry Dwelle*, North Dakota Department of Health
- *Linda Frazee*, Bureau of Local and Rural Health, Kansas Department of Health and Environment
- *Julie Gleason-Comstock*, Center for Urban Studies and Department of Family Medicine and Public Health Sciences, Wayne State University, MI
- *John Gwinn*, Kent City Board of Health, OH
- *Georgia Heise*, Three Rivers District Health Department, KY
- *Colleen Hughes*
- *Larry Jones*, City of Independence Health Department, MO
- *Louise Kent*, Northern Kentucky Health Department
- *Deb Koester*, West Virginia Bureau for Public Health
- *Cynthia D. Lamberth*, College of Public Health, University of Kentucky
- *Lisa Lang*, National Library of Medicine
- *Amy Lee*, Consortium of Eastern Ohio Master of Public Health, Northeastern Ohio Universities Colleges of Medicine and Pharmacy
- *Susan Lepre*, Consultant
- *William Livingood*, Institute for Public Health Informatics and Research, Duval County Health Department, FL
- *Bryn Manzella*, Jefferson County Department of Health, AL
- *Marcia Mills*, Minnesota Department of Human Services
- *Janet Place*, North Carolina Institute for Public Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
- *Beth Resnick*, Bloomberg School of Public Health, Johns Hopkins University, MD
- *William Riley*, School of Public Health, University of Minnesota
- *David Steffen*, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
- *Patricia Thompson-Reid*, Centers for Disease Control and Prevention
- *Susan Webb*, Center of Excellence in Public Health Workforce Research and Policy, College of Public Health, University of Kentucky
- *Kathleen Wright*, School of Public Health, Saint Louis University, MO

9. Core Competencies Workgroup Report

The Council on Linkages Between Academia and Public Health Practice

Core Competencies Workgroup Report

July 28, 2011

Overview

The Core Competencies Workgroup was originally established to develop the Core Competencies for Public Health Professionals (Core Competencies) and review them every three years for possible revision. The Workgroup's efforts have since expanded to promoting use of the Core Competencies and developing tools to assist organizations in using the Core Competencies. The Competencies to Practice Toolkit Subgroup was established and charged with developing a Competencies to Practice Toolkit to help public health practice organizations use the Core Competencies to better understand, assess, and meet their workforce and training needs. Various tools are currently under development, and a number of Subgroup members have indicated their willingness to participate in tool development and review. Refinement and development of specific tools by Subgroup members will begin shortly after this Council on Linkages Between Academia and Public Health Practice (Council) meeting with the addition of "e.g.s" to competencies and the creation of job descriptions based on the Core Competencies.

Combining the Workgroup and Subgroup

As the Council's Core Competencies-related work has shifted toward tool development, the Competencies to Practice Toolkit Subgroup has grown and taken an active role. The Subgroup currently has 34 members, more than double the membership of the Core Competencies Workgroup. In order to most effectively draw on the expertise of these volunteers and enable maximum participation in Council activities, the Chairs of the Core Competencies Workgroup and Competencies to Practice Toolkit Subgroup recommend that the Council combine the Workgroup and Subgroup. Diane Downing, RN, PhD, Chair of the Workgroup, and Janet Place, MPH, Chair of the Subgroup, are willing to serve as co-chairs of the combined group.

Presentations

The Core Competencies will be featured in several presentations at national meetings this fall, in addition to a recent presentation at NACCHO Annual 2011. At the Annual National Association of Local Boards of Health Conference, the Core Competencies will play a central role in a presentation on "How to Focus your Training and Professional Development Efforts to Improve Your Board's Skills to Govern and Lead." This presentation is scheduled for Wednesday, September 7th from 8:30-9:30 am. At the American Public Health Association Annual Meeting, a similar session will be presented. Entitled "How to Focus your Training and Professional Development Efforts to Improve the Skills of your Public Health Organization," this presentation will occur on Monday, October 31st from 8:30-10 am. A second presentation, entitled "Competencies to Practice Toolkit: A Repository of Workforce Development Resources for Public Health," is scheduled for October 31st from 4:50-5:10 pm.

The Council on Linkages Between Academia and Public Health Practice

Core Competencies Workgroup Members

Chair:

- *Diane Downing*, School of Nursing and Health Studies, Georgetown University, DC

Members:

- *Joan Cioffi*, Centers for Disease Control and Prevention
- *Mark Edgar*, University of Illinois at Springfield
- *John Gwinn*, The University of Akron, OH
- *Larry Jones*, City of Independence, MO
- *Denise Koo*, Centers for Disease Control and Prevention
- *Lisa Lang*, National Library of Medicine
- *John Lisco*, Centers for Disease Control and Prevention
- *Jeanne Matthews*, School of Nursing and Health Studies, Georgetown University, DC
- *Nancy McKenney*, Wisconsin Department of Health and Family Services
- *Kathy Miner*, Rollins School of Public Health, Emory University, GA
- *Janet Place*, North Carolina Public Health Academy, University of North Carolina

The Council on Linkages Between Academia and Public Health Practice

Competencies to Practice Toolkit Subgroup Members

Chair:

- *Janet Place*, North Carolina Public Health Academy, University of North Carolina

Members:

- *Nor Hashidah Abd Hamid*, Upper Midwest Public Health Training Center, IA
- *Geri Aglipay*, Mid America Public Health Training Center, IL
- *Sonya Armbruster*, Sedwick County Health Department, KS
- *Noel Barakat*, Los Angeles Department of Public Health, CA
- *Dawn Beck*, Olmsted County Public Health Services, MN
- *Michael S. Bisesi*, Ohio Public Health Training Center
- *Tom Burke*, Bloomberg School of Public Health, Johns Hopkins University, MD
- *Sarah Childers-Strawbridge*, Indiana Department of Health
- *Judith Compton*, Michigan Public Health Training Center
- *Marilyn Deling*, Olmsted County Public Health Services, MN
- *Taren Douglas*, Arizona Public Health Training Center
- *Mark Edgar*, Wisconsin Public Health Training Center
- *Joan Ellison*, Livingston County Department of Health, NY
- *Dena Fife*, Upper Midwest Public Health Training Center, IA
- *Rachel Flores*, University of California - Los Angeles
- *Linda Frazee*, Kansas Department of Health
- *Kari Guida*, Minnesota Department of Health
- *Louise Kent*, Northern Kentucky Health Department
- *David Knapp*, Kentucky Department of Health
- *Erin Louis*, Kentucky and Appalachia Public Health Training Center, KY
- *Kathleen Macvarish*, New England Alliance for Public Health Workforce Development, MA
- *Lynn Maitlen*, Indiana Department of Health
- *Nancy McKenney*, Wisconsin Department of Health Services
- *Nadine Mescia*, Florida Public Health Training Center
- *Sophi Naji*, Mid America Public Health Training Center, IL
- *Kay Nicholson*, Indiana Public Health Training Center
- *Beth Resnick*, Bloomberg School of Public Health, Johns Hopkins University, MD
- *Kathleen Smith*, Los Angeles Department of Public Health, CA
- *Chris Stan*, Connecticut Department of Public Health
- *Allison Thrash*, Minnesota Department of Health
- *Karen A. Tombs*, New Hampshire Public Health Training Center
- *Lillian Upton-Smith*, Arnold School of Public Health, University of South Carolina
- *Judy Voss*, Olmsted County Public Health Services, MN

10. Pipeline Workgroup Report

The Council on Linkages Between Academia and Public Health Practice

Pipeline Workgroup Report

July 28, 2011

Overview

The Pipeline Workgroup was established to assist the Council on Linkages Between Academia and Public Health Practice (Council) with identifying strategies for recruiting and retaining a skilled and competent public health workforce. In this capacity, the Workgroup convened an expert forum on recruitment and retention, developed strategies to alleviate worker shortages, conducted literature searches, and collected original data on public health workers. Data collected thus far are being summarized for release in a report currently under development, and data collection will be continued with the 2011 survey of public health workers (to include states not included in the earlier survey). Data from the 2010 survey specific to work settings and types of public health professionals are available for use by Council member organizations.

New Directions

The current economic and political environment presents an opportunity for the Council to consider how it can have the greatest impact on ensuring a skilled and competent public health workforce. As public health positions are eliminated in many health departments throughout the country, focusing on evidence-based recruitment and retention strategies may be less relevant to the immediate needs of the public health community. However, the activities of the Pipeline Workgroup have positioned the Council to explore opportunities presented by the public health and healthcare workforce provisions of the Affordable Care Act (ACA). The Pipeline Workgroup requests that the Council consider refocusing the Workgroup's direction to develop strategies for guiding implementation of the workforce provisions of the ACA. By bringing the public health practice and academic communities together around this important topic, effective strategies can be developed to meet immediate and longer-term needs of health departments and other public health organizations.

Background information about the workforce provisions of the ACA follows this document.

The Council on Linkages Between Academia and Public Health Practice

Pipeline Workgroup Members

Chair:

- *Vincent T. Francisco*, University of North Carolina at Greensboro

Members:

- *Susan Allan*, School of Public Health, University of Washington
- *Ralph Cordell*, Centers for Disease Control and Prevention
- *Pat Drehobl*, Centers for Disease Control and Prevention
- *Clese Erikson*, Association of American Medical Colleges
- *Julie Gleason-Comstock*, School of Medicine, Wayne State University, MI
- *Georgia Heise*, Three Rivers District Health Department, KY
- *Azania Heyward-James*, Centers for Disease Control and Prevention
- *Susan Lepre*, Consultant
- *Jean Moore*, Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York
- *Henry Taylor*, Bloomberg School of Public Health, Johns Hopkins University, MD
- *Tanya Uden-Holman*, School of Public Health, University of Iowa
- *Susan Webb*, College of Public Health, University of Kentucky
- *Marlene Wilken*, School of Nursing, Creighton University, NE

PRELIMINARY DRAFT

2010 Survey of Public Health Workers: Findings

Study Population:

In 2010 the Council on Linkages Between Academia and Public Health Practice, which is staffed b the Public Health Foundation, and the University of Kentucky joined together on the National Pipeline Survey to ask governmental public health workers employing Training Finder Real-time Affiliate Integrated Network (TRAIN), an online training system developed by the Public Health Foundation (PHF) TRAIN currently serves as the most widely used online learning system in public health. Currently 22 states' public health departments use TRAIN with more than 300,000 individual users located in all 50 states and a number of other countries.

Sampled governmental public health workers responded online to the Council of Linkages National Pipeline Survey, a recruitment and retention survey conducted in the spring and summer of 2010 and focusing on factors influencing the workers' decision to join and remain in the public health field. Drawing upon over 300,000 past and present users of the TRAIN online learning and training system, the researchers applied a filter to extract 82,209 users who could be identified in the system as governmental public health workers. Survey invitations to 11,820 of these users' email addresses, however, proved to be undeliverable. This left a sampling frame made up of 70,315 U.S. governmental public health workers identified among TRAIN users. The researchers then approached each of the 22 states who use TRAIN to seek the states' participation in the survey.

Additionally, a systemic random sample of 3,000 users was drawn from the 70,389 users in the sampling frame. These 3,000 invited participants were tracked and sent a special web address to access the online survey. The goal of the sampling approach was to achieve a minimum of 400 completed responses so as to have a nationally representative sample with a confidence level of 95% with a margin of error no greater than +/-5%. The sample of 3,000 invited participants represents an over-sampling to account for low response rates and inactive email accounts. This cross-sectional study employed descriptive statistics and multivariate analyses using SPSS version 18.0. In total 11,637 individual participated in the survey with 7559 indicating themselves as governmental public health workers as indicated by Table 1. Generally there were no significant differences between the large group and random sample population.

Table 1: Response Rate

Survey Deployed to	82,209
Survey Received by	70,315
Number of Respondents	11,637 (7559)
Target Response Rate	20%
Actual Response Rate	17%

Governmental Respondents

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Demographics of Survey and Governmental Respondents:

The most typical respondent of the Pipeline Survey consisted of a 48 year old, white, non-Hispanic, female, nurse who has worked a mean of 12.61 years as a public health professional including a mean of 11.06 years at her current public health agency. Thus, respondents' mean age are 47.27 years, and 78% of the respondents report being female. In terms of ethnicity, 7% of respondents self-identify as Hispanic, Latino or of Spanish origin and, as shown in Table 5, almost 4 out of 5 respondents describe themselves as White. Respondents answered from 40 of the 50 states as well as the District of Columbia. The majority of respondents were registered via the 22 states which regularly utilize the TRAIN system. Of these respondents 55% were from the states of AR, KS, KY, OH, OK, TX, VA, WI.

Table 2: Current Work Setting

Work Setting	N=11637
State Government	**46% (55%)***
Local Government	**27% (33%)***
Healthcare	**26% (19%)***
Nonprofit Organization	**10% (5%)***
Academia	**7% (4%)***
Private Industry	**3% (1%)***
Federal Government	**3% (4%)***
Self Employed	**2% (1%)***
Tribal or Territorial	**1% (1%)***
Unemployed	**3% (1%)***

Governmental Respondents

Over half of governmental respondents work for a state public health agency. Another third works for a local public health agency. Almost a third of respondents (31.4%) reports working in an agency serving fewer than 50,000 people.

Table3: Current Professional Roles

Nurse	**26%**

Administrator/Director/Manager	**21%**
Administrative Support	**15%**
Health Educator	**12%**
Non-clinical Public Health Service Provider	**12%**
Emergency Responder/Planner	**10%**
Allied Health Professional	**7%**
Environmental Health Specialist	**6%**
Faculty/Educator	**4%**
Data Analyst	**4%**
Biostats/Epi, Lab Prof., Researcher	**3% each**
Physician, Student	**2% each**

Making up 26% of respondents, nursing represents the most common professional role held by surveyed workers with over a fifth (21%) of respondents also listing they serve as an administrator or manager. The mean length of service in public health is 12.61 years with respondents reporting they have worked a mean of 11.06 years for their current agency. Prior to taking their current position, respondents report being in a range of activities with higher education (26.4%) and healthcare services (20.0%) the most commonly listed. The most commonly reported setting prior to entering public health for governmental public health respondents included healthcare services (31%) and private sector organizations (23%).

Table 4: Where Respondents Were Prior to Entering Public Health

School	High School – 2% **(4%)*** Associate Program – 3% **(5%)*** Undergraduate Program – 9% **(14%)*** Graduate Program – 8% **(12%)*** Doctoral/Advanced Program – 2% **(4%)***
Employment	Healthcare – 20% **(31%)*** Private Sector Org – 15% **(23%)*** Governmental Agency – 7% **(10%)*** Nonprofit Org – 7% **(10%)*** Academic Org – 4% **(6%)*** Self-Employed – 3% **(4%)***
Retired Unemployed	1% **(1%)*** 4% **(6%)***

Governmental Respondents

Sixty-five percent of workers report they had a bachelor's degree or higher when starting their careers in public health. By the time of the survey, 70% of workers report they have completed a bachelors degree or higher. In terms of a graduate degree, 26% of respondents began their public health careers with a masters degree or higher. At the time they answered the Pipeline survey, an additional 9% had completed a graduate degree. The highest increase in education was for those receiving a Master's degree (Table 5). These findings suggest that workers continue to pursue education during their careers in public health.

Table 5: Demographic Characteristics of Pipeline Survey Respondents

Race and Ethnicity	Percentage
American Indian or Alaska Native	2%
Asian	2%

Black or African American	8%
Native Hawaiian or other Pacific Islander	1%
White	78%
Hispanic/Latino/Spanish	7%

Educational Level	Highest Level Completed When First Became a Public Health Professional	Highest Currently Completed
High School	16% (13%)	13% (10%)
Associate degree	20% (17%)	19% (15%)
Bachelors degree in public health	4% (5%)	3% (4%)
Other bachelors degree	36% (40%)	32% (34%)
Masters degree in public health	5% (6%)	8% (10%)
Other masters degree	13% (13%)	18% (19%)
Doctoral degree in public health	<1% (<1%)	1% (1%)
Other doctoral degree	2% (2%)	2% (3%)
Other advanced degree (e.g. MD, JD,etc.)	4% (4%)	5% (5%)

Governmental Respondents

Recruitment:

As shown in Table 6 of rank of mean respondent ratings, respondents list specific work function/activities involved in their current position as the highest rated reason behind initially taking their current job. Respondents' rate job security, competitive benefits, and identifying with the mission of the organization among the greatest influences on their decision to initially take their current job. The ability to telecommute rated least important in recruitment among total respondents, but this factor did rate higher among younger workers in their 20s. Factors external to the position and agency such as a desire to live in a particular climate or close to family also rated fairly high. Perhaps in part influenced by the timing of this survey's administration during a national recession, job security has the second highest mean for recruitment influences and the highest mean for retention factors. Interestingly, benefits also rate considerably higher than competitive salaries for public health workers. In fact, competitive salaries rate 12th out of 19 factors.

Table 6: Factors Influencing Decision to Work with Current Employer

FACTORS	Entering	Remaining
Specific Work Functions or Activities Involved in Current Position	1	2
Job Security	2	1
Competitive Benefits	3	3
Identifying with the Mission of the Organization	4	4
Enjoy living in the area (e.g. climate, amenities, culture)	5	6
Personal commitment to public service	6	5
Wanted to live close to family and friends	7	8
Wanted a job in the public health field	8	9
Future Opportunities for Training/Continuing Education	9	10
Flexibility of Work Schedule	10	7
Ability to Innovate	11	11
Competitive Salary	12	14
Future Opportunities for Promotion	13	15
Autonomy/Employee empowerment	14	13
Needed a job, but it didn't matter if it was in public health	15	16
Immediate Opportunity for Advancement/Promotion	16	17

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Wanted to work with specific individual(s)	17	12
Family member/role model was/is working in public health	18	19
Ability to Telecommute	19	18

Retention*:*

The same factors highly influencing recruitment remain highly rated in terms of influencing retention (Table 6). Of note, however, are several trends. First, the workers answering this survey have been retained in public health. This survey lacks information on those individuals who have left the public health field. Retained workers rate their personal commitment to public service higher compared to when they initially took their jobs. The data reveal a trend towards valuing stability in terms of other highly rated factors: a) job security, b) enjoying living in an area, and c) living near family. Perhaps because many of these respondents are mid-career, they now rate opportunities for advancement future and immediate- lower now compared to when they began work.

Gender Differences*:*

Analysis of the data using a Chi-square procedure finds several statistically significant differences between female and male respondents. Women rate opportunities for training (p= .013) significantly more important as a recruitment factor. Women likewise rate several retention factors as more important than male respondents: autonomy/employee empowerment (p= .047), specific work functions (p= .003), and wanting a job specifically in public health (p= 0.23). On the other hand, men rate living near family and friends (p= .024), working with a specific person (p= .033), and personal commitment to public service (p= 0.33) highly as retention factors.

Age and Length of Employment Differences*:*

Younger workers rate several factors as more important to their recruitment and retention than older workers. The factors that were more important to those in their 20s and 30s included the ability to advance and job security. While older workers rate three factors –1) personal commitment to public service 2) identification with an agency's mission, and 3) specific duties related to job higher than their younger co-workers. These trends were also reflected in comparison in the factors influencing decision to work with current government employer by years spent as an employee of a governmental public health agency (Tables 7 and 8).

Table 7 - Average rating factors influencing decision to work with current government employer by years spent as an employee of a governmental public health agency

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How much did these factors influence your decision to take your first position with your current employer decision to work with current employer	In total, how many years have you spent as an employee of a governmental public health agency					
	<5	5-9	10-19	20+	F	p-value
Job Security	6.69	6.81	6.94	6.85	2.176	0.089
Flexible work schedule	5.45	5.10	5.06	4.88	7.911	<0.001
Ability to work from home	1.51	1.33	1.13	0.85	21.524	<0.001
Autonomy/Employee empowerment	4.55	4.19	4.06	3.79	14.859	<0.001
Specific duties and responsibilities	6.99	6.89	6.91	6.88	0.519	0.669
Identifying with the mission of the organization	6.61	6.39	6.46	6.46	1.670	0.171
Ability to innovate	5.42	5.18	5.04	5.03	5.652	0.001
Immediate opportunity for advancement/promotion	3.80	3.50	3.61	3.44	4.364	0.004
Future opportunities for promotion	5.03	4.62	4.56	4.40	11.521	<0.001
Opportunities for training/continuing education	6.07	5.52	5.50	5.38	16.684	<0.001
Competitive salary	4.89	4.67	4.40	4.44	8.436	<0.001
Competitive benefits	6.78	6.76	6.93	6.83	1.204	0.307
Enjoy living in the area (e.g. climate, amenities, culture)	5.82	5.11	6.06	6.39	7.473	<0.001
Wanted to live close to family and friends	5.66	5.79	5.79	6.00	2.245	0.081
Wanted to work with specific individual(s)	3.13	3.13	3.07	2.93	1.316	0.267
Wanted a job in the public health field	5.88	5.70	5.97	6.16	4.526	0.004
Needed a job, but it didn't matter if it was in public health	3.99	3.94	3.77	3.87	1.236	0.295
Personal commitment to public service	6.23	6.10	6.17	6.14	0.404	0.750
Family member/role model was/is working in public health	1.51	1.51	1.58	1.73	2.199	0.86

Table 8-Average rating factors influencing decision to work with current government employer by years spent as an employee of a governmental public health agency

How much did these factors influence your decision to take your first position with your current employer decision to remain working with current employer	In total, how many years have you spent as an employee of a GOVERNMENTAL public health agency					
	<5	5-9	10-19	20+	F	p-value
Job Security	7.20	7.31	7.60	7.80	15.001	<0.001
Flexible work schedule	6.12	5.92	6.15	6.00	1.512	0.209
Ability to work from home	1.98	2.01	1.80	1.60	6.124	<0.001
Autonomy/Employee empowerment	5.13	4.92	5.04	4.10	1.106	0.345
Specific duties and responsibilities	6.79	6.84	6.97	7.18	6.376	<0.001
Identifying with the mission of the organization	6.60	6.45	6.82	7.00	9.910	<0.001
Ability to innovate	5.53	5.50	5.53	5.77	2.496	0.058
Immediate opportunity for advancement/promotion	3.56	3.19	3.00	2.76	19.539	<0.001
Future opportunities for promotion	4.62	4.03	3.55	3.12	61.395	<0.001
Opportunities for training/continuing education	6.17	5.51	5.56	5.37	19.413	<0.001
Competitive salary	5.02	4.88	4.79	4.77	1.963	0.117
Competitive benefits	6.77	6.75	6.90	7.08	3.939	0.008
Enjoy living in the area (e.g. climate, amenities, culture)	6.14	6.47	6.60	6.93	14.691	<0.001
Wanted to live close to family and friends	5.94	6.09	6.33	6.48	6.930	<0.001
Wanted to work with specific individual(s)	5.10	4.91	5.14	5.09	1.264	0.285
Wanted a job in the public health field	5.99	5.88	6.40	6.67	17.934	<0.001
Needed a job, but it didn't matter if it was in public health	3.92	3.70	3.26	3.03	21.313	<0.001
Personal commitment to public service	6.47	6.48	6.88	7.17	19.411	<0.001

Family member/role model was/is working in public health	1.55	1.47	1.42	1.41	1.003	0.390

Differences by Race*:*

Analysis of the data by race also finds some statistically significant differences among workers, but these differences only emerge among retention factors. No differences by race emerge in terms of recruitment factors. Also, too few Native Hawaiian and Pacific Islander workers responded to include in analyses.

African-American respondents significantly rate the ability to work from home as more important than Native American workers with Asian and White workers' responses. The other three statistically significant differences reflect higher ratings by Asian respondents than the other three racial groups. Asian workers rate immediate opportunities for promotion, future opportunities for promotion and living near family and friends significantly higher than other groups.

Differences between Hispanic and non-Hispanic Respondents: Analysis by a Chi-square procedure of the data found six statistically significant differences between respondents who report their ethnicity as Hispanic or not. Hispanic respondents report flexibility of work schedule the ability to work from home , and having a family member or role model working in public health, are more important recruitment factors than for their non-Hispanic peers. In terms of retention, Hispanic workers rate the ability to innovate wanting a job in public health and having a role model or family member in public health as more important.

Other Findings:

There were some differences in regional importance in recruitment and retention factors. The Midwest and Southeast rated flexibility of work schedule more important than any other region. The West had a significantly younger proportion of respondents than other regions and ranked competitive salary, ability to telecommute and opportunities for promotion and advancing professionally higher than any other region. Also, competitive salary seemed to be more important for respondents who worked in larger health departments. Further analyses including length of public health employment by professional and organizational leadership by current job settings are included in the appendices.

Organizational Leadership, Management, Professional Development Characteristics:

Organizational leadership characteristics was determined by rating based off a 5 point Likert scale with the categories of strong agree, somewhat agree, neither agree or disagree, somewhat disagree, and strongly disagree. This was determined by rating of how strongly agree or disagree with the statements about their organization. While the majority of respondents rated that strongly agree or agree with all leadership characteristics as contained in table there was a over a third who did not agree that there is atmosphere of trust and mutual respect within their organization and that the management and staff have a shared vision (Table 9).

Table 9: Organizational Leadership Characteristics

	Strongly Agree or Agree	Strongly or Somewhat Disagree
Trust/Respect	56% (53%)*	33% (36%)*
High Professional Standards	65% (63%)*	22% (24%)*
Appropriate Performance Evaluations	53% (51%)*	28% (29%)*
Constructive Feedback	55% (52%)*	28% (29%)*
Shared Vision	56% (53%)*	31% (33%)*

Governmental Respondents

The majority of respondents rated that strongly agree or agree with all management characteristics to address employee concerns. However, there was over a third who did not agree that there is that management had properly addressed employee concerns about autonomy/employee empowerment and leadership issues (Table 10). Additionally, there was almost a third who did not feel like management properly addressed concerns about professional development which may be problematic in retaining employees.

Table 10 : Over the past 12 months, management in the organization has made a sustained effort to address employee concerns about:

	Strongly Agree or Agree	Strongly or Somewhat Disagree
Tools Needed to do Job	63% (60%)*	22% (24%)*

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Professional Development	60% (58%)*	24% (26%)*
Autonomy/Employee Empowerment	47% (45%)*	29% (31%)*
Leadership Issues	45% (44%)*	32% (34%)*
New Employee Support	48% (46%)*	23% (23%)*
Safety and Security	64% (62%)*	14% (15%)*

Governmental Respondents

Finally, when asked to rate the professional development of organization. There were only two areas where a majority of respondents agreed these included opportunities to learn from one another and provides employees with most needed knowledge and skills (table 11). An overwhelming majority felt that the organization did not have resources available for employees and over a third disagreed that there is adequate time provided and training to fully use technology for professional development. This suggests that even if an employee wants to pursue professional development opportunities for themselves there may neither resources or time.

Table 11: Please rate how strongly you agree or disagree with the following statements about professional development in your organization:

	Strongly Agree or Agree	**Strongly or Somewhat Disagree**
Resources Available for Employees	36% (33%)*	51% (55%)*
Adequate Time Provided	45% (43%)*	38% (41%)*

Training to Fully Use Technology	48% (45%)*	35% (39%)*
Opportunities to Learn from One Another	66% (65%)*	18% (19%)*
Provides Employees with Most Needed Knowledge and Skills	60% (58%)*	21% (23%)*

Governmental Respondents

Discussion:

The public health workforce represents a critical link in the nation's healthcare system. Like the American workforce as a whole, the public health workforce represents an aging group of employees with a deficit of trained professionals to fill roles vacated by retirements. Developing strategies to recruit and retain trained professionals who are eligible for retirement or who are attractive to potentially more lucrative private healthcare jobs offer important tools for public health agencies. The Council on Linkages and PHF are pursuing a second phase of the National Pipeline Survey among the 28 states that do not use TRAIN. This second survey will use the same questions but will employ a different methodology to reach workers.

While not generalizable to all public health workers nationally, the Pipeline Survey represents an important first step and the largest survey recruitment and retention survey of public health workers to date. Several potential strategies emerge from these data:

1. Linking the Individual Worker and the Public Health Mission: Respondents report the activities associated with a particular job rate the highest in job recruitment. Linked to these activities are other highly rated factors around identifying with the agency's mission, commitment to public service, and a desire to work in this field –factors which respondents rate higher actually now than when they began their job. Strategies which inculcate a stronger link between the agency's mission in improving public health and the personal commitment of the employee to this mission could help recruit and retain workers.
2. Benefits: Respondents consistently rate benefits higher than competitive salaries. With respondents rating job flexibility and proximity to family and friends higher in importance in retention, attractive benefits packages incorporating flex time, elder care, on-site daycare and similar benefits allowing workers greater flexibility to care for loved ones may be beneficial.
3. Training and Education: In terms of recruitment and retention, emphasizing training and educational opportunities may also offer attractive options for some workers. Five percent of workers who had not completed a bachelor's degree when they began their public health career did so by the time they answered the survey. Additionally, another 8.7% of respondents report they completed a graduate degree while working in public health. Respondents overall rate opportunities for training as moderately important (5.8 on a scale from 0 to 10) in their decisions to take and stay in a public health job. Offering workers trainings, tuition credits, and

scheduling flexibility to pursue more education is likely to be attractive to this segment of workers.

Beyond the information on individual public health workers gathered by this study, it also offers an important first venture into using the TRAIN system to research public health workers. As the largest database of public health and emergency responders in the country, it offers researchers an imperfect but possibly best current mechanism for studying the national public health workforce at the individual worker level.

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Appendices:

Primary professional role by years spent as employee of governmental public health agency

Primary Professional Role				
	<5	**5-9**	**10-19**	**20+**
Administrative Support staff	281 (26.9%)	228 (21.9%)	301 (28.9%)	233 (22.3%)
Administrator/Director/Manager	282 (15.5%)	331 (18.2%)	612 (33.6%)	598 (32.8%)
Allied Health Professional	146 (27.4%)	93 (17.4%)	159 (29.8%)	135 (25.3%)
Biostatistician/Epidemiologist/Statistician	115 (32.2%)	98 (27.5%)	96 (26.9%)	48 (13.4%)
Data Analyst	86 (27.6%)	84 (26.9%)	85 (27.2%)	57 (18.3%)
Environmental Health Specialist	104 (15.8%)	133 (20.2%)	186 (28.2%)	236 (35.8%)
Emergency Responder/Planner	229 (29.8%)	179 (23.3%)	212 (27.6%)	148 (19.3%)
Faculty/Educator	70 (27.8%)	62 (24.6%)	68 (27.0%)	52 (20.6%)
Health Educator	300 (31.0%)	213 (22.0%)	291 (30.1%)	163 (16.9%)
Laboratory Professional	60 (25.5%)	45 (19.1%)	66 (28.1%)	64 (27.2%)
Nurse	446 (22.7%)	399 (20.3%)	616 (31.3%)	507 (25.8%)
Physician	49 (28.8%)	36 (21.2%)	49 (28.8%)	36 (21.2%)

Public Health Service Provider (non-clinical)	257 (29.3%)	160 (18.2%)	267 (30.4%)	194 (22.1%)
Researcher	71 (38.0%)	47 (25.1%)	47 (25.1%)	22 (11.8%)
Student	57 (51.4%)	27 (24.3%)	18 (16.2%)	9 (8.1%)
Total	1884	1561	2181	1835

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Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by primary professional role of respondent

Please rate how strongly you agree or disagree or with the following statements about leadership in your organization:

Agree or Strongly Agree with	Primary Professional Role														
	Admin Support	Admin	AH	Biostat /Epi /Stat	Data Analyst	Environ	Emerg. Respon	Faculty Educator	Health Educator	Lab Prof	Nurse	MD	PH Service Provider (non-clinical)	Researcher	Student
There is an atmosphere of trust and mutual respect with the organization	918 (52.9%)	1455 (61.1%)	469 (55.9%)	200 (51.9%)	194 (46.8%)	384 (52.6%)	686 (60.4%)	280 (61.1%)	825 (57.7%)	194 (55.4%)	1719 (57.4%)	153 (63.0%)	762 (56.2%)	165 (59.3%)	903 (58.3%)
Management and staff have shared	903 (52.1%)	1485 (61.9%)	467 (55.6%)	193 (50.3%)	196 (47.4%)	354 (48.7%)	643 (56.7%)	282 (61.6%)	815 (57.2%)	175 (49.8%)	1785 (59.6%)	146 (60.6%)	725 (53.5%)	155 (55.9%)	141 (56.2%)

vision															
Employees are held to high professional standards for the work they do	981 (56.9%)	1630 (68.5%)	547 (65.2%)	222 (57.6%)	218 (52.7%)	476 (65.1%)	785 (69.4%)	320 (69.9%)	951 (66.7%)	230 (65.5%)	2092 (69.8%)	164 (68.0%)	874 (64.9%)	183 (65.6%)	159 (63.6%)
Employee performance evaluations are handled in an appropriate manner	877 (50.7%)	1298 (60.4%)	443 (53.1%)	188 (48.8%)	196 (47.2%)	350 (48.0%)	543 (47.8%)	258 (56.5%)	789 (55.3%)	171 (48.9%)	1739 (58.1%)	124 (51.2%)	693 (51.2%)	142 (50.9%)	128 (51.0%)
The procedures for employee performanc	852 (49.3%)	1247 (52.4%)	432 (51.7%)	197 (51.2%)	178 (42.9%)	351 (48.2%)	516 (45.7%)	248 (54.4%)	764 (53.8%)	169 (48.3%)	1659 (55.5%)	123 (51.2%)	669 (49.6%)	138 (49.9%)	125 (50.0%)

e evaluations are consistent															
Employees receive constructive feedback that can help them improve their performance	882 (51.0%)	1405 (59.0%)	453 (53.9%)	198 (51.5%)	196 (47.2%)	360 (49.2%)	611 (54.0%)	276 (60.3%)	816 (57.3%)	174 (49.7%)	1733 (58.0%)	123 (51.0%)	709 (52.4%)	141 (50.5%)	140 (55.8%)

Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by primary professional role of respondent

Over the past 12 months, management in the organization has made a sustained effort to address employee concerns about:

	Primary Professional Role														
Agree or Strongly Agree	**Admin Support**	**Admin**	**AH**	**Biostat /Epi/ Stat**	**Data Analyst**	**Environ**	**Emerg. Respon**	**Faculty Educator**	**Health Educator**	**Lab Prof**	**Nurse**	**MD**	**PH Service Provider (non-clinical)**	**Researcher**	**Student**
Tools needed to do my job	1042 (60.3%)	1525 (64.1%)	526 (63.0%)	220 (57.3%)	216 (52.7%)	439 (60.1%)	754 (66.5%)	306 (67.3%)	911 (64.2%)	196 (56.0%)	1932 (64.6%)	143 (58.9%)	847 (62.8%)	171 (61.2%)	160 (63.5%)
Professional development	923 (53.7%)	1488 (62.6%)	507 (60.7%)	218 (56.8%)	216 (52.5%)	414 (56.8%)	721 (63.7%)	289 (63.4%)	933 (65.6%)	166 (47.7%)	1892 (63.4%)	148 (61.4%)	794 (58.9%)	171 (61.3%)	161 (63.8%)
Autonomy/Employee empowerment	656 (38.2%)	1263 (53.1%)	391 (47.1%)	154 (39.9%)	155 (37.9%)	306 (42.0%)	574 (50.7%)	248 (54.3%)	727 (51.2%)	125 (35.9%)	1585 (52.9%)	111 (46.2%)	594 (44.2%)	135 (48.8%)	124 (49.8%)
Leadership issues	702 (40.9%)	1321 (55.5%)	366 (43.9%)	135 (35.3%)	149 (36.3%)	277 (38.2%)	566 (50.1%)	237 (52.5%)	670 (47.3%)	130 (37.4%)	1471 (49.2%)	128 (52.6%)	570 (42.4%)	117 (42.0%)	113 (44.8%)
New employee support	492 (46.3%)	1337 (56.2%)	385 (46.3%)	160 (41.8%)	158 (38.5%)	295 (40.5%)	593 (52.6%)	222 (48.8%)	689 (48.6%)	148 (42.4%)	1553 (52.0%)	117 (48.5%)	619 (45.9%)	128 (46.2%)	120 (48.0%)
Safety and security	1116 (64.9%)	1551 (65.3%)	528 (63.3%)	217 (56.5%)	239 (58.3%)	400 (54.7%)	734 (65.2%)	274 (60.2%)	920 (64.9%)	234 (67.0%)	1994 (66.7%)	152 (63.0%)	849 (63.0%)	158 (56.9%)	154 (61.4%)

Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by primary professional role of respondent

Please rate how strongly you agree or disagree with the following statements about professional development in your organization:

	Primary Professional Role (Question 19)														
Agree or Strongly Agree	**Admin Support**	**Admin**	**AH**	**Biostat /Epi/ Stat**	**Data Analyst**	**Environ**	**Emerg. Respon**	**Faculty Educator**	**Health Educator**	**Lab Prof**	**Nurse**	**MD**	**PH Service Provider (non-clinical)**	**Researcher**	**Student**
Sufficient fund/resources	556 (32.2%)	881 (37.1%)	337 (40.3%)	130 (36.0%)	135 (33.0%)	232 (31.7%)	481 (42.5%)	190 (41.6%)	622 (43.8%)	79 (22.6%)	1131 (37.8%)	89 (36.9%)	529 (39.1%)	107 (38.6%)	103 (41.0%)
Adequate time	651 (37.7%)	1097 (46.2%)	416 (49.8%)	176 (45.8%)	153 (37.4%)	319 (43.7%)	573 (50.6%)	233 (50.9%)	711 (49.9%)	107 (30.6%)	1387 (46.4%)	119 (49.4%)	666 (49.1%)	132 (47.7%)	130 (51.5%)
Employees have sufficient training to fully utilize technology needed for work	742 (43.2%)	1156 (48.8%)	443 (53.0%)	151 (39.6%)	152 (37.3%)	331 (45.4%)	593 (52.4%)	245 (53.8%)	712 (50.3%)	178 (51.4%)	1519 (50.9%)	120 (50.2%)	672 (49.8%)	132 (48.0%)	126 (50.2%)
Employees are provided with opportunities to learn from one another	1078 (62.3%)	1673 (70.5%)	555 (66.4%)	250 (64.9%)	252 (61.5%)	477 (65.5%)	799 (70.4%)	316 (69.4%)	951 (67.0%)	220 (63.1%)	2081 (75.5%)	157 (65.7%)	867 (64.2%)	191 (68.9%)	160 (63.5%)
Professional develop	926 (53.8	1496 (63.1%)	533 (64.	225 (58.6)	205 (50.	437 (60.	731 (64.	288 (63.4	923 (65.0	192 (54.	1888 (63.	136 (117.	837 (62.1	158 (57.1%	151 (60.0

ment	%)		0%)		0%)	0%)	9%)	%)	%)	9%)	2%)	1%)	%)	)	%)

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Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by work setting

Please rate how strongly you agree or disagree with the following statements about leadership in your organization:

Agree or Strongly Agree with	Current Work Setting (Question 17)										
	Academic Institution	Gov't Federal	Gov't State	Gov't ocal	Gov't Territory	Gov't Tribal	Health care Services	Non-Profit	Private Industry	Self-employed	Unemployed
There is an atmosphere of trust and mutual respect with the organization	489 (66.0%)	178 (56.0%)	2431 (48.1%)	1809 (61.1%)	9 (60.0%)	21 (55.3%)	1684 (59.5%)	669 (64.1%)	177 (59.2%)	62 (55.4%)	6 (46.2%)
Management and staff have shared vision	489 (66.1%)	164 (51.9%)	2442 (48.3%)	1763 (59.6%)	7 (73.3%)	21 (55.3%)	1691 (59.9%)	663 (63.6%)	170 (57.5%)	62 (55.4%)	9 (60.0-%)
Employees are held to high professional standards for the work they do	549 (73.9%)	202 (63.7%)	2941 (58.3%)	2083 (70.5%)	9 (64.3%)	19 (50.0%)	1940 (68.8%)	750 (72.2%)	209 (69.7%)	74 (66.1%)	10 (71.4%)

Employee performance evaluations are handled in an appropriate manner	415 (56.0%)	158 (50.1%)	2488 (49.3%)	1605 (54.4%)	5 (33.3%)	21 (55.2%)	1643 (58.2%)	601 (57.9%)	159 (53.4%)	47 (41.9%)	5 (35.7%)
The procedures for employee performance evaluations are consistent	407 (55.2%)	150 (47.9%)	2452 (48.6%)	1537 (52.1%)	6 (40.0%)	19 (50.0%)	1594 (56.5%)	569 (54.8%)	150 (50.2%)	49 (43.7%)	7 (50.0%)
Employees receive constructive feedback that can help them improve their performance	442 (59.7%)	154 (48.9%)	2523 (50.0%)	1700 (57.4%)	7 (46.7%)	21 (55.3%)	1659 (58.8%)	6331 (60.8%)	168 (56.4%)	60 (53.5%)	6 (42.9%)

Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by work setting

Please rate how strongly you agree or disagree with the following statements about leadership in your organization:

Agree or Strongly Agree with	Current Work Setting (Question 17)										
	Academic Institution	Gov't Federal	Gov't State	Gov't local	Gov't Territory	Gov't Tribal	Health care Services	Non-Profit	Private Industry	Self-employed	Unemployed
Tools needed to do my job	515 (70.1%)	188 (59.7%)	2835 (56.3%)	2041 (69.3%)	`12 (80.0%)	22 (59.4%)	1833 (65.4%)	708 (68.6%)	191 (65.2%)	59 (54.1%)	10 (62.6%)
Professional development	517 (70.5%)	192 (61.3%)	2641 (52.6%)	1965 (66.8%)	7 (46.6%)	23 (63.9%)	1725 (61.6%)	684 (66.1%)	179 (61.3%)	64 (58.2%)	12 (75.1%)
Autonomy/Employee empowerment	430 (58.6%)	145 (46.4%)	1934 (38.5%)	1583 (53.8%)	6 (40.0%)	18 (48.6%)	1385 (49.5%)	568 (55.2%)	150 (51.0%)	50 (45.9%)	8 (50.0%)
Leadership issues	393 (53.8%)	145 (46.2%)	1943 (38.8%)	1512 (51.5%)	8 (53.3%)	12 (33.3%)	1344 (48.0%)	548 (53.0%)	143 (48.7%)	41 (37.6%)	8 (50.0%)
New employee	378 (51.7	140 (45.	2216 (44.	1539 (52.4	5 (33.3	17 (45.	1472 (52.7%	545 (52.	147 (50.0	45 (41.3	7 (43.8%)

support	%)	0%)	2%)	%0	%)	9%)	)	7%)	%)	%)	
Safety and security	479 (65.2 %)	196 (62. 4%)	301 3 (59. 9%)	1984 (67.7 %)	12 (80.0 %)	23 (62. 1%)	1902 (68.0%)	696 (67. 5%)	187 (63.8 %)	57 (52.3 %)	11 (68.8%)

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Number of respondents who agreed or strongly agreed with positive statements about organization or leadership within their workplaces by work setting

Please rate how strongly you agree or disagree with the following statements about professional development in your organization

Agree or Strongly Agree with	Current Work Setting (Question 17)										
	Academic Institution	Gov't Federal	Gov't State	Gov't local	Gov't Territory	Gov't Tribal	Health care Services	Non-Profit	Private Industry	Self-employed	Unemployed
Sufficient fund/resources	351 (48.1%)	137 (44.4%)	1436 (28.6%)	1201 (41.0%)	4 (28.5%)	20 (55.6%)	1098 (39.5%)	481 (46.9%)	138 (47.7%)	39 (35.8%)	5 (31.3%)
Adequate time	409 (56.2%)	149 (48.9%)	1865 (37.3%)	1502 (51.4%)	7 (46.7%)	18 (50.0%)	1275 (45.9%)	556 (54.2%)	140 (48.3%)	47 (43.5%)	7 (43.8%)
Employees have sufficient training to fully utilize technology needed for work	428 (59.1%)	154 (50.4%)	2052 (41.1%)	1525 (52.3%)	10 (73.3%)	20 (55.5%)	1465 (52.8%)	594 (58.0%)	164 (56.8%)	45 (41.3%)	7 (43.8%)
Employees are provided with opportunities to learn	508 (69.8%)	203 (66.6%)	3052 (61.0%)	2104 (72.0%)	11 (73.3%)	21 (58.3%)	1913 (69.0%)	734 (71.5%)	217 (74.8%)	72 (66.1%)	9 (56.3%)

from one another											
Professional development	496 (68.4%)	190 (62.1%)	2642 (52.9%)	1934 (66.4%)	9 (60.0%)	23 (63.9%)	1750 (63.2%)	684 (66.9%)	186 (64.4%)	66 (60.0%)	8 (50.0%)

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Positions held by public health workers immediately prior to entering your current governmental public health position

Where were you before entering your current governmental PH position?	Current Professional Role														
	Admin Support	Admin	Allied Health …	Biostat /Epi /Stat	Data Analyst	Environ	Emergency Responder	Faculty Educator	Health Educator	Lab Prof	Nurse	MD	PH Service Provider (non-clinical	Researcher	Student
High School	75	47	14	5	9	24	48	10	32	7	38	3	32	4	4
Associate Degree	72	68	32	4	14	13	61	10	40	12	143	1	44	6	11
Undergrad PH program.	9	59	18	12	6	82	26	7	58	6	26	1	29	3	7
Other Undergrad program	65	224	68	30	37	124	88	18	124	50	160	2	79	28	19
Graduate	19	120	21	140	39	33	57	32	92	12	29	22	55	36	14

program in public health															
Other graduate program	27	133	66	23	27	49	48	19	70	20	66	2	58	21	7
Doctoral program in public health	0	8	2	15	4	1	0	9	3	2	1	0	2	11	1
Other doctoral program	6	33	17	5	7	8	7	12	6	5	1	33	9	7	2
Other advanced degree program (eg MD, JD, etc)	5	39	11	14	3	7	5	17	6	3	9	44	9	10	4
Other governmental agency	173	239	42	19	49	84	107	19	85	15	79	8	111	19	8

Healthcare Services	147	549	191	65	32	51	224	77	300	72	1356	73	256	30	28
Nonprofit Organization	72	232	84	36	26	23	98	27	175	14	147	11	135	26	11
Private Industry	405	385	82	46	89	253	202	34	169	63	309	14	225	29	38
Academic employment	30	125	33	60	34	33	45	41	104	20	68	22	68	30	10
Retired	12	25	5	0	3	11	17	1	5	4	12	4	13	2	0
Self Employed	52	71	27	11	13	36	56	16	54	6	40	21	59	11	5
Unemployed	125	62	24	20	28	45	32	7	50	15	63	3	43	11	8
Total	1294	2419	737	1891	417	861	1121	356	1373	326	2547	264	1227	284	177

Patient Protection and Affordable Care Act (HR 3590)
Selected Prevention, Public Health & Workforce Provisions

Selected Prevention and Public Health Provisions

Essential Health Benefits Requirements (Sec. 1302) – Includes an essential health benefits package that covers essential health benefits defined by the Secretary and limits cost-sharing. Included in the general benefit categories are preventive and wellness services and chronic disease management, maternity and newborn care, mental health and substance use disorder services, and pediatric services, among other things.

Coverage of Preventive Health Services (Sec. 2713) – Stipulates that a group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for:
(1) evidence based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the US Preventive Services Task Force (USPSTF);
(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC with respect to the individual involved;
(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA;
(4) with respect to women, additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by HRSA;

States that for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

States that nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by the Task Force.

Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan (Sec. 4103) – Provides Medicare Part B coverage, with no co-payment or deductible, for personalized prevention plan services. Personalized prevention plan services means the creation of a plan for an individual that includes a health risk assessment and may include other elements, such as updating family history, listing providers that regularly provide medical care to the individuals, BMI measurement, and other screenings and risk factors. The personal prevention plan would take into account the findings of the health risk assessment and would be completed prior to or as part of a visit with a health professional. The personalized health advice and referral may include community-based lifestyle interventions to reduce health risks and promote self-management and wellness, as well as lists of risk factors and a screening schedule.

Directs the Secretary to establish publicly available guidelines for health risk assessments, standards for interactive telephonic or web-based programs to furnish health-risk assessments and a health risk assessment model.

Removal of Barriers to Preventive Services in Medicare (Sec. 4104) – Waives coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services, an initial preventive physical examination and any covered preventive service if it is recommended with a grade of A or B by the USPSTF. Clarifies that cost sharing for colorectal cancer screening services would be waived.

Evidence-Based Coverage of Preventive Services in Medicare (Sec. 4105) – Provides the Secretary with the authority to modify coverage of existing preventive services, consistent with USPSTF recommendations. It would allow the Secretary to withdraw Medicare coverage for services not rated as A, B, C, or I by the USPSTF.

Improving Access to Preventive Services for Eligible Adults in Medicaid (Sec. 4106) – The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the USPSTF and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices and their administration. States that cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid (4107) - States would be required to provide Medicaid coverage for counseling and pharmacotherapy for tobacco cessation by pregnant women. Prohibits cost-sharing for these services.

Incentives for Prevention of Chronic Diseases in Medicaid (Sec. 4108) – Directs the Secretary to award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who successfully participate in a healthy lifestyles program and demonstrate changes in health risk and outcomes. The program shall be comprehensive, evidence-based, widely available, and easily accessible and shall be proposed by the state and approved by the Secretary. It shall be designed to address the needs of Medicaid beneficiaries to achieve: ceasing the use of tobacco; controlling or reducing weight; lowering cholesterol; lowering blood pressure; avoiding the onset of diabetes or improving management of diabetes. The programs shall last for 5 years. The section includes impact assessments, evaluation and reporting requirements. The section appropriates $100 million for the program, out of any funds not otherwise appropriated in the Treasury.

National Prevention, Health Promotion & Public Health Council (Sec. 4001) – Creates a Council within HHS to provide coordination and leadership at the Federal level, and among Federal departments and agencies, with respect to prevention, wellness and health promotion

practices, the public health system and integrative health care in the U.S. & to develop the National Prevention Strategy. The Council shall be composed of departmental Secretaries from across the federal government, with the Surgeon General serving as Chair.

National Prevention and Health Promotion Strategy (Sec. 4001) – Tasks the Council with creating a national strategy to: set goals and objectives for improving health through federally-supported prevention, health promotion and public health programs, establish measurable actions and timelines to carry out the strategy, and make recommendations to improve Federal prevention, health promotion, public health and integrative health care practices.

Prevention and Public Health Fund (Sec. 4002) Establishes a fund, to be administered through the Office of the Secretary at HHS, to provide for an expanded and sustained national investment in prevention and public health programs (over the FY 2008 level). The Fund will support programs authorized by the Public Health Service Act, for prevention, wellness and public health activities, including prevention research and health screenings and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs. Funding levels: FY 2010 - $500 million; FY 2011 - $750 million; FY 2012 - $1 billion; FY 2013 - $1.25 billion; FY 2014 - $1.5 billion; FY 2015 and each fiscal year thereafter- $2 billion.

Community Health Centers and the National Health Service Corps Fund (Sec. 10503) - Creates a Community Health Center Fund that provides enhanced funding for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers. Fund totals $10 billion over 5 years. **Of note, the President's proposal would invest $11 billion in Community Health Centers over five years.

Clinical and Community Preventive Services Task Forces (Sec. 4003) – Defines, clarifies duties of, and provides better coordination between the U.S. Preventive Services Task Force and the Community Preventive Services Task Force.

Education & Outreach Campaign Regarding Preventive Benefits (Sec. 4004) - Directs the Secretary to provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan.

Requires the Secretary, acting through the CDC Director, to establish and implement a national science-based media campaign on health promotion and disease prevention. Directs the Secretary, acting through the CDC Director, to enter into a contract for the development and operation of a Federal Internet website personalized prevention plan tool. Funding for activities authorized under this section shall take priority over funding provided by CDC for grants with similar purposes. Funding for this section shall not exceed $500 million.

Directs the Secretary to provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults. States shall design

a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services. The Secretary shall report on the status and effectiveness of these efforts.

School-Based Health Centers (Sec. 4101) – Directs the Secretary to award grants to support the operation of school-based health centers, with an emphasis on communities with barriers in access to health services. Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of the fiscal years FY 2010-2013 $50 million for expenditures for facilities and equipment or similar expenditures. Authorizes the Secretary to award grants to pay the costs associated with expanding and modernizing existing buildings for use as a School-Based Health Center.

Oral Health (Sec. 4102) Directs the Secretary (subject to the availability of appropriations) to establish a 5-year national public health education campaign focused on oral healthcare prevention and education. Establishes demonstration grants to show the effectiveness of research-based dental caries disease management. Includes various oral health improvement provisions relating to school-based sealant programs, oral health infrastructure, and surveillance.

Community Transformation Grants (Sec. 4201) – Authorizes CDC to award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Eligible entities shall submit to the Director a detailed plan including the policy, environmental programmatic and as appropriate infrastructure changes needed to promote healthy living and reduce disparities. Activities may focus on creating healthier school environments, creating infrastructure or programs to support active living and access to nutritious foods, smoking cessation and other chronic disease priorities; implementing worksite wellness; working to highlight healthy options in food venues; reducing disparities; and addressing special population needs. The section includes evaluation and reporting requirements.

Healthy Aging, Living Well; Evaluation of Community-Based Prevention; and Wellness Programs for Medicare Beneficiaries (Sec. 4202) - Authorizes the Secretary, acting through the CDC Director, to award competitive grants to health departments and Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and when necessary, clinical referrals for individuals who are between 55-64 years old. Grantees must design a strategy to improve the health status of this population through community based public health interventions. Intervention activities may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health and promote healthy lifestyles among the target population. Screenings may include mental health/behavioral health and substance abuse disorders; physical activity, smoking and nutrition; and any other measures deemed appropriate by the Secretary. The section includes an evaluation component.

The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. The evaluation shall include programs sponsored by

the Administration on Aging that are evidence-based and have demonstrated potential to help Medicare beneficiaries reduce their risk of disease, disability and injury by making healthy lifestyle choices. CMS and AOA shall also conduct an evaluation of exiting community prevention and wellness programs. The Secretary shall submit a report to Congress on recommendations to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries; relevant findings; and the results of the evaluation.

Removing Barriers and Improving Access to Wellness for Individuals with Disabilities (Sec. 4203) – Requires the establishment of standards for accessible medical diagnostic equipment for individuals with disabilities.

Immunizations (Sec. 4204) – Authorizes states to obtain additional quantities of adult vaccines through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary and authorizes a demonstration program to improve immunization coverage. Reauthorizes the Immunization Program under Section 317 of the PHSA. Requires a GAO study and report on Medicare beneficiary access to vaccines and coverage of vaccines under Medicare Part D.

Nutrition Labeling of Standard Menu Items at Chain Restaurants (Sec. 4205) – Establishes nutrition labeling of standard menu items at chain restaurants (20 or more locations doing business under the same name). This includes disclosing calories on menu boards and in a written form, available on request, additional information pertaining to total calories and calories from fat, amounts of fat and saturated fat, cholesterol, sodium, total and complex carbohydrates, sugars, dietary fiber, and protein.

Demonstration Project Concerning Individualized Wellness Plan (Sec. 4206) – Directs the Secretary to establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan designed to reduce risk factors for preventable conditions identified by a comprehensive risk-factor assessment.

Reasonable Break Time for Nursing Mothers (Sec. 4207) – Requires employers to provide reasonable break times for nursing mothers and a place, other than a bathroom, which may be used to express breast milk. Employers with less than 50 employees shall not be subject to this requirement if it would impose an undue hardship by causing significant difficulty or expense.

Research on Optimizing the Delivery of Public Health Services (Sec. 4301) – Directs the Secretary, acting through the CDC Director, to fund research in the area of public health services and systems. Research shall include examining best practices relating to prevention, with a particular focus on high priority areas identified by the Secretary in the National Prevention Strategy or Healthy People 2020; analyzing the translation of interventions to real-world settings; and identifying effective strategies for organizing, financing or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

Understanding Health Disparities: Data Collection and Analysis (Sec. 4302) – Requires the Secretary to ensure that any ongoing or federally conducted or supported health care or public health program, activity, or survey collects and reports, to the extent practicable, data on race, ethnicity, gender, geographic location, socioeconomic status, language and disability status, in addition to data at the smallest geographic level. The Secretary shall analyze the data to detect and monitor trends in health disparities and disseminate this information to relevant Federal agencies.

Employer-Based Wellness Programs (Sec. 4303) – Directs CDC to provide employers with TA, consultation and tools in evaluating wellness programs and build evaluation capacity among workplace staff. Directs CDC to study and evaluate employer-based wellness practices. Clarifies that any recommendations, data or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.

Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs (Sec. 10408) - Directs the Secretary to award grants to small businesses to provide employees with access to comprehensive workplace wellness programs.

Pain Management (Sec. 4305) – Calls for an IOM Conference on Pain and includes various provisions relating to pain research and pain care education and training.

Funding for Childhood Obesity Demonstration Project (Sec. 4306) – CHIPRA established a Childhood Obesity Demonstration Project and authorized $25 million for FY 2009-2013. This section appropriates $25 million for the Secretary to carry out the demonstration project in FY 2010 – FY 2014.

Effectiveness of Federal Health and Wellness Initiatives (Sec. 4402) - Requires the Secretary of HHS to evaluate all existing Federal health and wellness initiatives and report to Congress concerning the evaluation, including conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

Better Diabetes Care (Sec. 10407) - Directs the Secretary, acting through the CDC Director, to prepare on a biennial basis, a national diabetes report card. Directs the Secretary and the IOM to study the impact of diabetes on the practice of medicine and the level of diabetes medical education that should be required prior to licensure, board certification and board recertification.

Cures Acceleration Network (Sec. 10409) - Requires the NIH Director to establish a Cures Acceleration Network to accelerate the development of high need cures, including the development of medical products and behavioral therapies.

Centers of Excellence for Depression (Sec. 10410) - Establishes a Network of Health Advancing National Centers of Excellence for Depression.

Programs Relating to Congenital Heart Disease (Sec. 10411) - Authorizes the Secretary, acting through the Director, to establish programs relating to congenital heart disease, including the formation of a National Congenital Heart Disease Surveillance System.

Young Women's Breast Health Awareness and Support of Young Women Diagnosed with Breast Cancer (Sec. 10413) - Establishes a public education and a healthcare professional education campaign regarding women's breast health.

National Diabetes Prevention Program (Sec. 5316) - Creates a CDC National Diabetes Prevention Program targeted at adults at high risk for diabetes, which entails a grant program for community-based diabetes prevention program model sites.

Selected Workforce Provisions

National Health Care Workforce Commission (Sec. 5101) **–** Establishes a commission to serve as a national resource for Congress, the President, States and Localities, determine whether the demand for health care workers is being met, identify barriers to coordination and encourage innovation. It shall disseminate information on retention practices for health care professionals and shall review current and projected health care workforce supply and demand and make recommendations regarding healthcare workforce priorities, goals and policies. The Commission shall communicate and coordinate with a variety of federal agencies and departments. Specific topics to be reviewed include health care workforce supply and distribution, health care workforce education and training capacity; existing education loan and grant programs, the implications of federal policies; the healthcare workforce needs of specific populations, and recommendations creating or revising loan repayment and scholarship programs. Public health professionals are included in the definition of health care workforce and the definition of health professionals. Public health workforce capacity is also included in the high priority areas list.

State Health Care Workforce Development Grants (Sec. 5102) –
Establishes a competitive healthcare workforce development grant program to enable State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. Authorizes $8 million for planning grants and $150 million for implementation grants for FY 2010 and such sums for each subsequent year.

Health Care Workforce Program Assessment (Sec. 5103) – Codifies the existing National Center for Health Care Workforce Analysis to provide for the development of information describing the health care workforce and the analysis of related issues and collect, analyze and report data related to programs under this title. The National Center and relevant regional and State centers and agencies shall collect labor and workforce information and provide analyses and reports to the Commission.

Public Health Workforce Recruitment and Retention Programs (Sec. 5204) – Establishes a public health workforce loan repayment program to eliminate critical public health workforce shortages in Federal, State, local and tribal public health agencies. Individuals receiving assistance must work at least three years in these agencies. In FY 2010, $195 million is authorized to be appropriated for this program, and such sums as necessary for FY 2011-2015. Sec. 5205 creates allied health workforce recruitment and retention programs.

Training for Mid-Career Public and Allied Health Professionals (Sec. 5206) - Authorizes the Secretary to make grants or enter into contracts to award scholarships to mid-career public health and allied health professionals to enroll in degree or professional training programs. Authorizes $60 million for these programs in FY 2010 and such sums as necessary for FY 2011-2015.

Elimination of cap on Commissioned Corps (Sec. 5209) This section strikes the required cap of 2,800 for members of the Regular Corps.

Establishing a Ready Reserve Corps (Sec. 5210) - Assimilates active duty Ready Reserve Officers into the Regular Corps & establishes a Ready Reserve to participate in training exercises, be available and ready for involuntary calls to active duty during national emergencies and public health crises, be available for deployment and for backfilling positions left vacant during deployment of active duty Corps members, and be available for service in isolated, hardship & medically underserved communities. This section authorizes $5 million for FY 2010 – FY 2014 for carrying out the duties and responsibilities of the Commissioned Corps under this section and for recruitment and training; and $12.5 million for the Ready Reserve Corps for FY 2010 – FY 2014.

Grants to Promote the Community Health Workforce (Sec. 5313) – Directs the Director of CDC to award grants to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

Epidemiology-Laboratory Capacity Grants (Sec. 4304) Directs the Secretary (subject to the availability of appropriations) to establish an Epidemiology and Laboratory Capacity Grant Program to award grants to eligible entities to assist public health agencies in improving surveillance for and response to infectious diseases and other conditions of public health importance. Authorizes $190 million for each year of fiscal years 2010-2013 to carry out this section.

Fellowship Training in Public Health (Sec. 5314) – Authorizes funding for fellowship training in applied public health epidemiology, public health laboratory science, public health informatics, and expansion of the epidemic intelligence service in order to address documented workforce shortages in State and local health departments. Authorizes, for each of fiscal years 2010 through 2013, $5 million for epidemiology fellowship training programs, $5 million for laboratory fellowship training programs; $5 million for the Public Health Informatics Fellowship Program; and $24,500,000 for expanding the Epidemic Intelligence Service.

Training in General, Pediatric and Public Health Dentistry (Sec. 5303) – Authorizes the Secretary to make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital or a public or private nonprofit entity to plan, develop and operate or participate in an approved professional dentistry program; to provide financial assistance to dental students, residents, practicing dentists and dental hygiene students, and for other purposes.

United States Public Health Sciences Track (Sec. 5315) Authorizes the establishment of a United States Public Health Sciences Track with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team based service, public health, epidemiology, and emergency preparedness and response. Students receive tuition remission and a stipend and are accepted as Commissioned Corps officers with a 2-year service commitment for each year of school covered. Included among the graduates shall be 100 public health students annually. Includes a provision that would develop elite federal disaster teams.

Preventive Medicine & Public Health Training Grant Program - Directs the Secretary to award grants to or enter into contracts with eligible entities to provide training to graduate medical residents in preventive medicine specialties.

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ISSUE BRIEF

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The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges

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About APHA
The American Public Health Association is the oldest and most diverse organization of public health professionals in the world and has been working to improve public health since 1872. The Association aims to protect all Americans, their families and their communities from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

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EXECUTIVE SUMMARY

A main tenet of the Affordable Care Act (ACA), the health care reform law signed in March 2010, is to transform our "sick care" system into one that focuses on prevention and health promotion. The success of this transformation largely rests on a sufficiently sized, adequately trained workforce that can provide the community and clinical preventive health services that are needed to promote and protect the nation's health.

Despite the importance of public health to the well-being of society, the workforce responsible for ensuring the public's health faces critical challenges, including:

- substantial decreases in funding, resources, and staff,
- inadequate training, and
- inequitable distribution in areas of greatest need.

The recent economic downturn accelerated declines in the governmental public health workforce. Estimates indicate approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce, were lost between 2008 and 2010.[1,2] Worker shortages and budget cuts mean public health workers have to do more with less, which exacerbates the already difficult task of worker recruitment and retention, and results in reduced public health services. Among state health agencies, nearly nine out of 10 (89%) cut services between 2008 and 2010.[2]

Recognizing this, the ACA included a set of provisions designed to enhance the supply and training of both the health care and the public health workforces:

Health Workforce Training. The ACA reauthorizes existing programs—as well as creates new programs—that provide loan repayment, scholarships, fellowships, residencies, and other support to new and existing public health and clinical health care workers across workplaces and the educational spectrum.

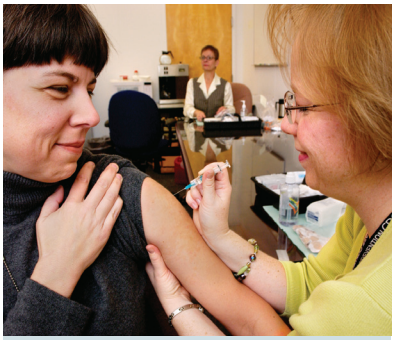
Public Health Infrastructure. The ACA invests in public health infrastructure, providing support for the hiring of public health workers, and enhancing the workforce's capacity to serve the public's needs, particularly in times of health emergencies. Included in these provisions is elimination of the cap on the number of Commissioned Corps members, establishment of the Ready Reserve Corps, and new grants to enhance public health epidemiology and laboratory capacity.

New Public Health Programming. The ACA makes investments in public health and community-based programming to support preventive and health promotion activities that will require trained public health workers. These provisions include Community Transformation Grants and a new home visiting program for new and expectant parents.

Health Workforce Analysis and Planning. The law creates an independent National Health Care Workforce Commission to review current and projected health workforce needs, including those of public health, and to make recommendations to Congress and the Administration on workforce policies. The law also provides support for workforce planning at the state level, and enhances support for the national, state, and regional health workforce analysis centers.

The health workforce provisions in the ACA have the potential to substantially address the training, recruitment, retention, informational, and worker supply needs facing the public health workforce, particularly at governmental health agencies. However, the promise of these provisions will only be fulfilled if they are fully funded. To date only 11 of the 19 provisions described in this document have received funding. And among those that have been funded, the funding levels are substantially lower than authorized (ie. recommended) levels. Furthermore, a majority of the funding has gone towards the clinical care workforce, as opposed to the public health workforce as a whole.

With the fiscal situation only worsening, the future funding situation of the ACA's workforce provisions is very unclear. Public health workers help to create healthier communities—ones with adequate access to preventive health services, and healthy environments at home, school and work. Sustained, adequate funding is needed to make this vision a reality.



Public health workers help to create healthier communities—ones with adequate access to preventive health services, healthy food options at school and work, and a well-educated and prepared workforce to respond to emerging population health threats and natural disasters.

I. Introduction

A main tenet of the Affordable Care Act (ACA), the health care reform law signed in March 2010, is to transform our "sick care" system into one that focuses on prevention and health promotion. The new law sparked an ongoing conversation about how to infuse health promotion and prevention across policies and programs throughout the health care sector. As stated by Senator Tom Harkin, an author of the ACA, "America's health care system is in crisis precisely because we systematically neglect wellness and prevention." The success of these prevention and public health efforts largely rests on a sufficiently sized, adequately trained workforce that can provide the public health and clinical health services that are needed to reorient our public health and health care systems toward prevention. Recognizing this, the ACA included a substantial set of provisions designed to enhance the supply and training of both the health care and the public health workforces. This brief provides a summary of the current challenges faced by the public health workforce, a summary of the ACA provisions that address these challenges, and an examination of key issues moving forward with the implementation of the ACA's workforce provisions.

II. Current Challenges Facing the Public Health Workforce

The public health workforce provides the essential services needed to ensure safe communities and enable individuals to live healthy lives. Despite the importance of public health to the well-being of society, the workforce responsible for ensuring the public's health faces critical challenges, including substantial decreases in funding, resources, and staff; inadequate training; and inequitable distribution in areas of greatest need. This section describes the size and composition of the public health workforce, as well as the trends and challenges facing that workforce as it strives to meet the health needs of the American public.

A. OVERVIEW OF THE PUBLIC HEALTH WORKFORCE

The Institute of Medicine (IOM) defines a public health professional as "a person educated in public health or a related discipline who is employed to improve health through a population focus".[3] While sharing this population-level focus on health, public health workers are employed across multiple types of settings, and represent a range of disciplines, skills, and educational and training backgrounds. Of the estimated 500,000 individuals that constitute the public health workforce, the majority (about 85%) are employed at governmental public health agencies, including the nearly 3,000 local health departments, 56 state and tribal agencies, and the many federal agencies responsible for public health, such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ).[4] The remaining 15% of the public health workforce are employed at nonprofit organizations, academic and research institutions, medical groups and hospitals, and private companies. It should be noted that these numbers are only rough estimates based on agency and employer surveys. Due to its diversity and range of settings, and the absence of funding for enumeration efforts, the exact size and composition of the public health workforce remain uncertain.

The public health workforce includes health educators, program administrators, public health physicians, nurses, veterinarians, dentists, epidemiologists, first responders, food inspectors, laboratory scientists, and environmental health specialists (including sanitarians), among others. Public health workers vary in their educational attainment, ranging in backgrounds from high school to doctoral degrees. Those who have advanced degrees receive training in a range of disciplines and academic settings, including schools of public health, social work, nursing, medicine, allied health, law, public administration, engineering, biology, and journalism.

The public health workforce's focus on population-level health distinguishes it from the health care workforce that provides

Approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce, were lost between 2008 and 2010 due to the economic downturn.

clinical health care and medical services to treat individuals in clinical settings. That workforce includes physicians, nurses, and allied health professionals such as physical and occupational therapists and radiological technicians. However, there is no clear boundary between public health and health care. For example, many governmental public health staff collaborate with clinicians in the health care sector,[5] and many clinically trained professionals such as physicians and nurses work in public health settings.[3] In addition, nearly 60% of state health officials have a medical degree (M.D. or D.O.).[6] Public health workers, including those employed at governmental agencies and in the private non-profit and for-profit sectors, together with health care workers comprise what can be called the "health workforce."

B. CHALLENGES FACING THE PUBLIC HEALTH WORKFORCE

Despite the importance of public health to the well-being of society, the public health workforce faces critical challenges, including substantial decreases in funding, resources, and staff; inadequate training to address emerging public health needs; and inadequate distribution in areas of greatest need.

Funding problems and worker shortages. Governmental health agencies have suffered from a workforce shortage for over a decade. From 1980, the size of the public health workforce at governmental health agencies is estimated to have decreased by 50,000,[7] despite a 22% (50 million people) increase in population.[8] Achieving in 2020 the workforce ratio of 1980 – 220 public health workers for every 100,000 U.S. residents – would require 700,000 public health workers; the Association of Schools of Public Health (ASPH) projects that the United States will come up short of meeting this goal by 250,000 workers.[7] Although it is not clear that the workforce-population ratio from 1980 is the ideal ratio, the differences in ratios and the dramatic decrease in public health workers over time are striking.

The recent economic downturn accelerated declines in the governmental public health workforce. Estimates indicate that approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce were lost between 2008 and 2010.[1,2] In the second half of 2009 alone, 46% of local health departments lost skilled public health workers, representing 8,000 jobs lost due to layoffs and attrition, or approximately 5% of the local public health workforce; nearly three-quarters (73%) of the U.S. population live in areas affected by these lost positions.[1] Similarly, according to interviewed experts, in just the last 18 months, public health laboratories witnessed a 10% decrease in their workforce, amounting to 600 laboratory professionals at every level. In addition to job losses, 13,000 local health department employees experienced cuts to working hours or mandatory furloughs in the last half of 2009.[1] One-time funding from the American Recovery and Reinvestment Act (ARRA) and H1N1 supplemental funds helped many health departments bridge funding gaps and maintain jobs in 2009-2010, but these funds are one-time funds. The loss of ARRA and H1N1 funds in the coming year is expected to result in additional job losses.[1]

Remaining workers have increased workloads, and recruitment of new workers is more difficult. Worker shortages and budget cuts mean public health workers at governmental health departments have to do more with less, thereby straining the capacity of the existing workforce and exacerbating the already difficult task of worker recruitment and retention.[9] At governmental health agencies in particular, working conditions can be demanding and difficult, and the salaries and employee benefits at health departments lag behind those in other settings.[9,10] Furthermore, public health agencies face a "graying" workforce. In 2012, nearly

one-quarter (23%) of the current public health workforce, an estimated 125,000 workers, will be eligible to retire.[7,10] By comparison, in 2009, about 88,000 federal employees retired,[11] representing 3% of the total federal workforce of 2.65 million.[12] In 2007, more than half of states reported they had trouble recruiting qualified applicants, particularly nurses.[13] Rural areas have a particularly difficult time recruiting public health nurses, physicians, and dentists when vacancies arise.[14] However, enrollment at master's of public health (MPH) programs has increased,[15] and many Americans report an interest in working in public health at the state or local government levels.[13] It remains to be seen how this growing interest in public health careers affects worker recruitment and retention in governmental, non-profit, and other public health settings.

Lack of training and a career pipeline. Unlike other fields of health such as medicine or nursing, there is no one typical career path or academic preparation for public health.[16] Many public health workers at state, local, territorial, and tribal health departments lack adequate education and training. A 2001 Centers for Disease Control and Prevention (CDC) report found that four out of five public health workers had no formal training for their specific activities.[17] More recently, a 2008 survey found that only 20% of local health departments' top executives held a public health degree.[1] In 2009, about one-third of state health officials had a masters of public health degree.[6] The lack of training in public health at governmental health agencies likely reflects the historical lack of public health training and educational programs, combined with the low proportion of public health graduates who pursue careers in governmental public health. In 2001, the Association of Schools of Public Health (ASPH) reported that there were 29 accredited schools of public health in the United States,[18] with 20,247 applicants; just eight years later, there were 43 accredited schools of public health with 43,368 applicants.[15] In recent years, only 20% of graduates in public health have entered careers at public health departments,[16] contributing to an aging workforce. Although nearly all state health agencies conducted in-house staff training in 2008, only 60% use the IOM-established *Core Competencies for all Public Health Workers*.[6] Further, more than half (57%) of state health agencies' 2009 budget for workforce training and development decreased in 2009, and 30% were anticipating decreases in 2010.[6] Continuous learning or in-service training is less common among local health departments; fewer than half of local health departments have a budget line item for staff training, and fewer local health departments were using the IOM's *Core Competencies* in 2008 than in 2005.[1] Despite the need, there continue to be few training opportunities for the existing public health workforce.[19-22]

Workforce diversity and geographic distribution. There are demonstrated racial, ethnic, and geographic disparities in the public health workforce.[23] Although public health programs have a higher proportion of underrepresented minority applicants and enrollees than other health professions schools, ethnic and racial minority students accounted for fewer than 20% of public health students in 1999, compared to about 28% in the general population.[24] Border counties in particular report unmet needs for bilingual and culturally competent public health staff.[14] Further, few racial and ethnic minority public health workers hold executive positions; in 2008, 93% of local health departments' top executives were White and 98% were non-Hispanic.[1] In addition to exhibiting racial and ethnic disparities, the public health workforce displays significant gaps across geographic areas.[25] A diverse, geographically distributed workforce is needed to meet the health needs of our increasingly diverse population.

C. WORKFORCE SHORTAGES RESULT IN FEWER PUBLIC HEALTH SERVICES

Drastic budget cuts and workforce shortages have forced difficult decisions at state, local, territorial, and tribal public health agencies, often resulting in fewer services. Among state health agencies, nearly nine out of 10 (89%) reduced services between 2008 and 2010, especially programs related to health promotion, disease-specific intervention, and laboratory services.[2] From

July 2008 to June 2009 alone, 55% of local health departments cut at least one public health program; 26% cut three or more.[1,26] These cuts in screenings and other preventive activities will result in higher costs in the long term, as prevention and preventive services save money in the long term.[1] One nationwide survey indicated that, on average, only two-thirds of the core public health activities assessed (including assessment, policy development, and assurance activities) are offered in each community,[27] and several studies have found that the capacity of local health departments to prevent, prepare for, and respond to health threats varies widely across the nation.[9,27,28]

Although there is scant research on how public health workforce shortages and reduced services have affected health outcomes, fewer services and service providers are likely to have, or already have had, negative effects on the health of communities. Research indicates that local health departments with larger staffs and higher per capita funding tend to be higher-performing than departments with fewer staff and financial resources.[29,30] In turn, the performance of local health departments, through public health services such as laboratory analyses and hazard prevention and response, has a substantial influence on community health outcomes, including premature death rates[31] and various measures of mortality.[32] Increases in the number of full-time-equivalents (FTEs) at local health departments per capita are associated with decreases in cardiovascular disease deaths.[33] One recent news article in Nebraska detailed the impact that budget cuts have had on access to prenatal care and screenings; since prenatal care for more than 1,600 low-income women was cut, women are traveling more than 150 miles for prenatal care, and at least five babies have died.[34] A March 2011 *Washington Post* article described how health departments across the country have reduced staff and services as a result of decreased property tax revenues. Reduced funding in El Paso County, CO, stopped the monitoring of air and water quality; in Vermilion County, IL, the public health department cut 35 public health nurses, reducing immunizations and STD screenings.[35] The negative effects of decreased funding and staff on public health are expected to worsen in the near future. As one expert noted, "we haven't seen the wave crash yet; the impacts will be more evident in the next 12 to 18 months."

III. The Affordable Care Act's Workforce Provisions

Recognizing the need for a larger and better trained health care and public health workforce, the Affordable Care Act (ACA) included several provisions designed to enhance the supply and training of this workforce. These provisions can be divided into five sections: Health Workforce Training, Public Health Infrastructure, New Public Health Programming, Health Workforce Analysis and Planning, and Funding. This section summarizes the provisions in the ACA that could support and enhance the public health workforce, and analyzes how these provisions may address some of the challenges described in the previous section. A list of the provisions discussed in detail is provided in Table 1. Throughout this section, we distinguish between authorizations of appropriations (ie. discretionary spending), which require appropriation during future yearly congressional budgeting processes for funds to actually be available for the executive branch to spend; and mandatory appropriations, which are funds directly appropriated by the ACA and which do not require any further congressional action to be available to be spent.

A. HEALTH WORKFORCE TRAINING

The ACA expanded existing and created new programs designed to increase the supply and enhance the training of workers

89% of state health agencies reduced services between 2008 and 2010, especially programs related to health promotion, disease-specific intervention, and laboratory services.[2] 55% of local health departments cut at least one public health program from 2008 to 2009.

across the health workforce. This section first describes the provisions that target public health workers, and then describes provisions targeting the clinical health care workforce.

1. Public Health Workforce Training

Five provisions in the ACA are designed to support the training and education of public health workers in a variety of public health disciplines, including the following two new programs. First, the law created the ***Public Health Workforce Loan Repayment Program*** *(Section 5204)*, a new program in the Department of Health and Human Services (DHHS) that provides up to $35,000 in loan repayment to public health and allied health professionals who agree to work for at least three years at a federal, state, local, or tribal public health agency or fellowship after graduation. Students enrolled in their final year of study or who recently completed a public health or health professions degree or certificate, and have accepted a position or are employed by a governmental health agency or training fellowship, are eligible. Several interviewed experts cited the importance of funding for the loan repayment program, as it would have substantial effects on the recruitment and retention of governmental public health workers because many new graduates are saddled with student debt, and governmental public health positions traditionally pay lower salaries than do similar jobs in the private sector. To train existing public health workers, the ACA created ***Mid-career Training Grants*** *(Section 5206)* for HRSA to provide grants to support scholarships for mid-career professionals in public health or allied health working in federal, state, tribal, or local public health agencies or clinical health care settings to further their education in health. Neither of these two new programs has received any funding through FY2011.

The ACA also reauthorized the existing ***Preventive Medicine and Public Health Training Grants*** *(Section 10501(m)(1))*, which includes both physician residency programs in preventive medicine, and Public Health Training Centers for public health professionals. Administered by HRSA, the program provides grants to support residency training for physicians in preventive medicine, and grants for Public Health Training Centers, which offer opportunities to integrate public health into medical training, as recommended by the IOM.[3] The ACA expanded the eligibility of preventive medicine residencies to allow accredited schools of public health and medicine to partner with hospitals and state, local, and tribal health departments for grants, which can provide residents with opportunities to expand their expertise across settings. During the 2009–2010 academic year, five residency programs supported a total of 39 graduates, of which 36% were from minority backgrounds. Public Health Training Centers focus on continuing education for public health professionals in the core competencies identified by the Council on Linkages between Academia and Public Health Practice for current public health workers. During the 2009-2010 academic year, 181,688 existing public health workers received training at the Public Health Training Centers. The preventive medicine residencies and the Public Health Training Centers together were authorized at $43 million for FY2011. In FY2010, $9 million from the Prevention and Public Health Fund (see section IV) funded nine new awards for an estimated 17 resident physicians during the 2010–2011 academic year. In FY2010, $16.8 million was awarded to support a total of 33 Public Health Training Centers at schools of public health and other public and nonprofit institutions.[36] According to estimates, the President's 2012 proposed budget request of $25 million for the preventive medicine residencies and Public Health Training Centers would train 44 residents and 389,331 existing public health workers.[37]

To alleviate state and local health department shortages of professionals in public health epidemiology, public health lab science, and public health informatics, the law expanded the authorization for the existing ***Fellowship Training in Public Health*** *(Section 5314)* program at the CDC that provides fellowships in epidemiology, laboratory science, and informatics, the Epidemic Intelligence Service (EIS), and other public health science training programs. The stature authorized $24.5 million per year for FY2010 through 2013 for EIS fellowships and $5 million per year each for epidemiology, labo-

Several interviewed experts cited the importance of funding for the loan repayment program, as it would have substantial effects on the recruitment and retention of governmental public health workers because many new graduates are saddled with student debt, and governmental public health positions traditionally pay lower salaries than do similar jobs in the private sector.

ratory, and informatics fellowships. However, in FY2010, only $8 million was appropriated for the fellowships (from the Prevention and Public Health Fund). In FY2011, $250 million from the Prevention and Public Health Fund was appropriated to the fellowships.

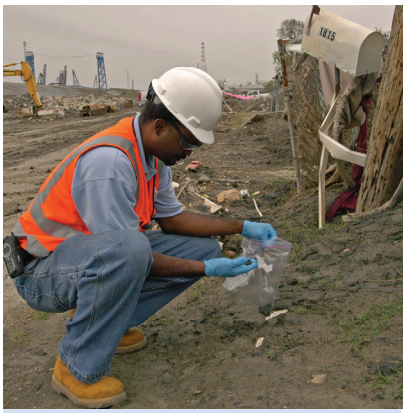
In addition, the ACA created the ***U.S. Public Health Sciences Track*** *(Section 5315)*, a new training track at selected schools of medicine, dentistry, nursing, public health, behavioral and mental health, physician assistance, and pharmacy to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness and response. The Surgeon General would administer the track, and participation entails a requirement to serve in the Commissioned Corps of the Public Health Service (see section III, B). The track would be funded through transfers from the Public Health and Social Services Emergency Fund, which provides supplemental funding for health hazard preparedness and emergency response activities, including funds for the Office of the Assistant Secretary for Preparedness and Response (ASPR) and pandemic influenza. In his 2012 budget proposal, President Obama proposed funding the Emergency Fund at $1.3 billion. Virtually all of the funds are allocated to DHHS agencies for award and use in disaster areas, but some funds may be used to support the Track.

2. Clinical Health Care Provider Training

In addition to provisions aimed specifically at the public health workforce, the ACA includes several provisions designed to increase the supply of and enhance training for clinical health care providers—particularly primary care providers—to meet the anticipated higher demand for health care services for millions of newly-insured individuals after 2014. In addition to providing training for health care providers who may work in public health settings, many of these provisions infuse public health concepts into training and educational programs for new and existing clinical health providers.

The ACA expanded and improved the existing ***National Health Service Corps (NHSC)*** *(Sections 5207, 5508(b), 10501(n), 10503)* program, which provides scholarships and loan repayments to primary, dental, and mental and behavioral health care providers who practice in medically underserved areas. The ACA increased the loan repayment amount from $35,000 to $50,000, allowed for part-time service, and allowed recipients' teaching to be counted toward their two-year service requirement. This provision differs from many of the other prevention and workforce initiatives in the ACA in that it includes mandatory funding that is not subject to the annual appropriations process. The NHSC will receive a total of $1.5 billion in mandatory funds from FY2011 through FY2015. For FY2011, the ACA appropriated $290 million, allowing NHSC clinicians to serve an estimated 9.9 million individuals, up from 5.9 million in FY2009. The President's FY2012 budget requests $124 million in discretionary funds for the NHSC in addition to the $295 million in mandatory funds appropriated by the ACA. For FY2012, the administration's target goal is to have 10,683 primary care clinicians in health professional shortage areas compared to 7,530 in FY2010.

To support collaboration between existing primary care providers and public health providers, the law also created the ***Primary Care Extension Program*** *(Section 5405)*, a new program modeled from of the Cooperative Extension Service at the U.S. Department of Agriculture. The program will support and educate existing primary care providers about preventive medicine, health promotion, chronic disease management, evidence-based therapies, and other health care related issues. Local, community-based health workers would serve as health extension agents, providing assistance in implementation of quality improvement strategies or culturally appropriate practices, and link primary care practices to health system resources, including governmental health departments. The University of New Mexico Health Sciences Center's Health Extension Rural Offices (HEROs) is one example of how this program might work in other locales. HEROs link community health needs to university resources to improve population health. HEROs are involved in youth recruitment and community-based workforce training initiatives, and collect data on public health needs and community health status.[38] The ACA authorized $120



Public Health Training Centers focus on continuing education for public health professionals in the core competencies identified by the Council on Linkages between Academia and Public Health Practice for current public health workers. During the 2009–2010 academic year, 181,688 existing public health workers received training at the Public Health Training Centers.

TABLE 1: Public health workforce provisions summary and funding status

TYPE	CATEGORY	PROVISION	SUMMARY	FY10-FY14 ACA AUTHORIZATIONS AND APPROPRIATIONS[1]	FY10-FY14 FUNDING STATUS, FY12 PRESIDENT'S BUDGET REQUEST[2]
HEALTH WORKFORCE TRAINING	Public Health Workforce Training	**Public Health Workforce Loan Repayment Program (Section 5204)**	Creates a new program that provides up to $35,000 in loan repayment for public health professionals who work for a minimum of three years at a federal, state, local, or tribal public health agency.	FY10: $195 m FY11-14: SSAN	
		Mid-Career Training Grants (Section 5206)	Creates a new grants program to support scholarships for mid-career public health and allied health professionals working in public health agencies for advanced education.	FY10: $60 m FY11-14: SSAN	
		Preventive Medicine and Public Health Training Grants (Section 10501(m)(1))	Expands the existing preventive medicine residency program at HRSA to support training to preventive medicine physicians at schools of public health, medicine, hospitals, and state, local, or tribal health departments. The law also expands the Public Health Training Center program at HRSA to support continuing education in core competencies for current public health workers.	FY11: $43 m FY12-14: SSAN	FY10: Prev Med Res: $9 m from PPHF; 27 Public Health Training Centers: $16.8 m ($15 m from PPHF) FY11: $29.6 m ($20 m from PPHF) *FY12 PBR: $25.1 m ($15 m from PPHF)*
		Fellowship Training in Public Health (Section 5314)	Expands the existing health fellowships program to train public health professionals in epidemiology, laboratory science, and informatics, the Epidemic Intelligence Service (EIS), and other training programs that meet public health science workforce needs.	FY10-13: $39.5 m ($24.5 m for EIS, $5 m for each of the other programs)	FY10: $8 m FY11: $20 m from PPHF *FY12 PBR: $25 m from PPHF*
		U.S. Public Health Sciences Track (Section 5315)	Creates a new public health sciences track at selected schools of medicine, dentistry, nursing, public health, behavioral and mental health, physician assistance, and pharmacy to train health professionals in team-based service, public health, epidemiology, and emergency preparedness and response.	FY10 and onwards: SSAN from Public Health and Social Services Emergency Fund	
HEALTH WORKFORCE TRAINING	Clinical Health Care Provider Training	**National Health Service Corps (Sections 5207, 5508(b), 10501(n), 10503)**	Expands the existing National Health Service Corps program, which provides scholarships and loan repayments to primary, dental, and mental and behavioral health care providers who practice in medically underserved areas for a minimum of two years. The law also increased the loan repayment amount from $35,000 to $50,000, allowed for part-time service, and allowed for teaching to be counted toward recipients' service requirement.	FY10: $320 m disc FY11: $290 m mand/$414 m FY12: $295 m mand/$535 m FY13: $300 m mand/$691 m FY14: $305m mand/$893 m FY15: $310 m mand/$1,154 m	FY10: $141 m (discretionary) FY11: $290 m (mandatory) + $141m (discretionary) FY12: $295 m (mandatory); *PBR: $124 m (discretionary)*
		Title VII Health Professions (Sections 5301, 5303, 5307, 5401, 5402, 5403)	Expands the Title VII programs that support training in primary care, dentistry, physician's assistants, and mental and behavioral health providers (Sections 5301 and 5303) and enhances the Title VII workforce diversity provisions, including Centers of Excellence (Section 5401), Area Health Education Centers (AHECs) (Section 5403), and loan repayment and scholarship initiatives (Section 5402), and improves a program to train providers in cultural competency, prevention, public health, and working with individuals with disabilities (Section 5307).	FY10: $390 m total	FY10: $241 m discretionary total for all Title VII Health Professions + $200 m from PPHF for primary care training FY11: $241 m *FY12 PBR: $404 m*
		Title VIII Nursing Education Programs (Sections 5202, 5208, 5308, 5309, 5310, 5311, 5404 10501(e))	Expands the Title VIII programs that support training and diversity in nursing, including student loan programs (Section 5202), grants and scholarships for undergraduate and graduate nursing education and retention (Sections 5308, 5309), loan repayment for nurse faculty (Section 5310, 5311), a new nurse-managed health clinic program (Section 5208), and a new demonstration program for family nurse practitioner training (Section 10501(e)), and grants to help minority individuals complete associate or advanced degrees in nursing (Section 5404).	$338 m total	FY10: $244 m discretionary total for all Title VIII programs + $30 m from PPHF for nursing education FY11: $244 m *FY12 PBR: $313 m*
		Primary Care Extension Program (Section 5405)	Creates a new program, modeled from the Agricultural Cooperative Extension Service, to provide support and information about preventive medicine, health promotion, chronic disease management, evidence-based therapies, and other health care-related issues to practicing primary care providers.	FY11-12: $120 m FY13-14: SSAN	

TYPE	CATEGORY	PROVISION	SUMMARY	FY10-FY14 ACA AUTHORIZATIONS AND APPROPRIATIONS[1]	FY10-FY14 FUNDING STATUS, FY12 PRESIDENT'S BUDGET REQUEST
Public Health Infra-Structure		**Elimination of Cap on Commissioned Corps (Section 5209)**	Eliminates the previous cap of 2,800 for active Regular members of Commissioned Corps members in the U.S. Public Health Service.		
		Establishing a Ready Reserve Corps (Section 5210)	Transfers all of the current members of the U.S. Public Health Service Corps to the Regular Commissioned Corps, and creates a new Ready Reserve Corps consisting of personnel who can assist Regular Corps members in times of emergencies.	FY10-14: $17.5 m	
		Epidemiology and Laboratory Capacity Grants (Section 4304)	Expands the National All-Hazards Preparedness for Public Health Emergencies program by adding a grant program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.	FY10-13: $190 m	FY10: $20 m from PPHF FY11: $40 m from PPHF *FY12 PBR: $40 m from the PPHF*
		Grants to Promote the Community Health Workforce (Section 5313, 10501(c))	Creates a new program for the CDC to award grants to states, local health departments, health clinics, hospitals, or community health centers promote positive health behaviors in underserved communities through the use of community health workers.	FY10-14: SSAN	
		Grants for the construction and operation of School-Based Health Centers (Section 4101)	Creates new grant programs to fund construction and operations of School-Based Health Centers.	Construction: FY10-13: $50 m mandatory each year Operation: SSAN	FY11: $50 m *FY12 PBR: $50 m*
New Public Health Programming		**Maternal, Infant, and Early Childhood Home Visiting Program (Section 2951)**	Creates a new grant program to support states, tribes, and certain nonprofit agencies in funding early childhood home visiting programs, focused on reducing infant and maternal mortality by enhancing prenatal, maternal, and newborn health; child health and development, parenting skills, school readiness, and family economic self-sufficiency.	All mandatory: FY10: $100 m FY11: $250 m FY12: $350 m FY13: $400 m FY14: $400 m	$88 m in mandatory funding released in July 2010
		Community Transformation Grants (Section 4201)	Creates a new program modeled on the Communities Putting Prevention to Work (CPPW) program included in the American Recovery and Reinvestment Act (ARRA) that provides support for evidence-based, community-based activities to promote health and prevent chronic diseases, such as smoking cessation or prevention programs, or enhanced access to nutrition or physical activity.	FY10-14: SSAN	FY11: $145 m from PPHF ($100m in grants released May 2011) *FY12 PBR: $221 m from PPHF*
Health Care Workforce Analyis		**National Health Care Workforce Commission (Sections 5101, 10501(a))**	Creates an independent, 15-member Commission tasked to review health care workforce supply and demand, and make recommendations on national priorities and policies regarding the recruitment, retention, and training of the health care workforce.	SSAN	*FY12 PBR: $3 m*
		National Center for Workforce Analysis (Section 5103)	Codifies and expands the existing National Center for Health Care Workforce Analysis at HRSA and establishes State and Regional Centers for Health Workforce Analysis to research and identify workforce gaps and needs. The Center oversees the State Health Care Workforce Development Grants.	FY10-14: $7.5 m for National Center, $4.5 m for State and Regional Centers	FY10: $2.8 m FY11: $2.8 m *FY12 PBR: $20 m*
		State Health Care Workforce Grants (Section 5102)	Establishes a new competitive grants program to fund workforce planning, development, and implementation activities.	FY10: $158 m, SSAN for subsequent years	FY10: $5.75 m from PPHF *FY12 PBR: $51 m*

1 Funding is discretionary unless otherwise indicated. m=million, SSAN=such sums as necessary, PPHF=Prevention and Public Health Fund. For more information about the Prevention and Public Health Fund, visit: *http://www.healthcare.gov/news/factsheets/prevention02092011b.html*.

2 FY12 PBR= President's Budget Request for Fiscal Year 2012. Note that the President's Budget Request does not guarantee those funds will be appropriated, as final appropriations are made by Congress. For more information about the President's 2012 budget proposal regarding the health workforce, visit: *http://www.hhs.gov/about/hhsbudget.html*.

Most of the ACA workforce programs that have mandatory funding or have received discretionary funds target the clinical health care workforce; only two of the five programs aimed at training public health workers have received funds, and one of these, the preventive medicine residency program, trains physicians.

million for the program for each of FY2011 and FY2012 and such sums as necessary through FY2014. To date, the program has not received funding.

The law reauthorized the ***Title VII Health Professions*** program, which supports the training and diversity of primary care providers, dental health providers, physician's assistants, and mental and behavioral health providers. This includes the primary care cluster—the ***Title VII Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship*** *(Section 5301)* program, which provides grants to develop and operate training programs for primary care physician and physician's assistant training at health professions schools. Because of the ACA, funds can be used to plan, develop, and operate joint degree programs to provide interdisciplinary graduate training in public health, including disease prevention and health promotion, epidemiology, and injury control. The law authorized $125 million for primary care training in FY2010, and such sums as necessary through FY2014. Oral health care provider training had previously been included in the primary care cluster; the law created a separate ***Title VII Training in General, Pediatric, and Public Health Dentistry*** *(Section 5303)* program that provides training, financial assistance, and grants for dental students, residents, hygienists, practicing dentists, or dental faculty in the fields of general, pediatric, and public health dentistry. Grants may be made to support partnerships between schools of dentistry and public health so that dental residents or hygiene students may receive master's-level training in public health. In 2009, the 35 active grantee dentistry programs trained more than 500 residents; the ACA allowed for an expansion of the program to 70 active grantees in 2010. In the ACA, $30 million was authorized for training in dentistry for FY2010, and such sums as necessary through FY2015. These clusters consistently have received funding, in varying amounts. In FY2010, the primary care and oral health care programs together received $54.4 million. Primary care workforce initiatives received additional funding from the ACA's Prevention and Public Health Fund in FY2010: $168 million was awarded to create additional primary care residency slots, and $32 million was awarded to support physician's assistant training. There is evidence that these programs are successful in encouraging providers to practice in underserved areas. The President's FY2012 budget justification reports that in FY2011, 43% of health professionals supported by Title VII entered practice in underserved areas, up from 35% in 2009. President Obama's proposed FY2012 budget requests $139.9 million for primary care training, which would train an estimated 4,000 additional primary care providers over five years, and $49.9 million for oral health care training.

Title VII Health Professions also includes programs that enhance the diversity of the health care workforce. The ***Centers of Excellence*** *(Section 5401)* program, designed to enhance the recruitment, training, and academic performance of minority individuals interested in health careers, was reauthorized, and the authorization was increased to $50 million per year. The President's FY2012 budget requests a continuation of FY2010 and FY2011 funding levels of $24.6 million for the Centers of Excellence. The ***Interdisciplinary, Community-based Linkages*** *(Section 5403)* provision reauthorized Area Health Education Centers (AHECs), which target individuals in urban and rural underserved communities seeking careers in health care or public health. The provision now also includes an option to operate a Youth Health Service Corps. The program was authorized at $125 million per year from FY2010 through FY2014. AHECs were funded at $33.3 million in FY2010, with a slight increase to $34.8 million in the President's FY2012 proposed budget. The ***Health Professions Training for Diversity*** *(Section 5402)* program provides scholarships for disadvantaged students who commit to working in underserved areas as primary care providers, and loan repayment to individuals serving as faculty at health professions schools. The scholarships program was authorized at $60 million for FY2010, but actually received $49.2 million. The President's FY2012 budget requests $60 million. The faculty loan repayment program was authorized at $5 million per year, but only received $1.3 million in FY10, and the President's budget requests

the same $1.3 million level for FY2012. The ACA reauthorized ***Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training*** *(Section 5307)*, a program to develop and disseminate curricula to support health care provider training to meet the needs of an increasingly diverse patient population, and expanded the program to emphasize training in public health. The program was authorized at such sums as necessary, and has yet to receive funding.

To support and enhance the nursing workforce, the ACA reauthorized and expanded the ***Title VIII Nursing Workforce Development*** programs that support the training and diversity of nurses across the educational spectrum. Title VIII includes: student loan programs *(Section 5202)*, grants and scholarships to undergraduate and graduate nursing education and retention *(Sections 5308, 5309)*, loan repayment for nurse faculty *(Section 5210, 5211)*, a new nurse-managed health clinic program *(Section 5208)*, and a new demonstration program for family nurse practitioner training *(Section 10501(e))*. Title VIII was authorized at $338 million for FY2010 and such sums as necessary through FY2016 *(Section 5312)*. Title VIII also supports ***Workforce Diversity Grants*** *(Section 5404)*, which were expanded to be used to help minority individuals complete associate or advanced degrees in nursing. In FY2010, nursing education programs received $227.7 million and nursing workforce diversity grants received $16.1 million. Also in FY2010, an additional $30 million was allocated from the Prevention and Public Health Fund to support nurse education.[39] The President's FY2012 budget requests a total of $293.1 million in funds for nursing education, and an additional $20 million for Title VIII nursing workforce diversity.

B. PUBLIC HEALTH INFRASTRUCTURE

Several provisions in the ACA focus on increasing the size of the public health workforce. One of these was ***Elimination of Cap on Commissioned Corps*** *(Section 5209)*, which removed the cap on the Commissioned Corps and transferred all Reservists to the active Commissioned Corps. The Commissioned Corps of the U.S. Public Health Service is one of the nation's seven uniformed services. It consists of 11 categories of health professionals, such as physicians, pharmacists, environmental health experts, nurses, veterinarians, and mental health professionals, who work across federal agencies, including the National Institutes of Health (NIH) and the Indian Health Service (IHS). Commissioned Corps members are tasked to respond to public health crises and national emergencies, such as natural disasters, disease outbreaks, or terrorist attacks. Previously, there was a Congressionally mandated cap of 2,800 active members of the Regular Corps. There were an additional 3,200 members of the U.S. Public Health Service Reserve Corps, and another 3,000 inactive or retired members who were not part of the "active" Corps. Reservists were less likely to receive promotions and had less job protection during force reductions than Regular Corps members.[16] The elimination of the Commissioned Corps cap is expected to dramatically increase the number of Commissioned Corps members, although Corps members must now be confirmed by the Senate, and no additional funding was authorized or appropriated to fund an increase in the size of the Corps. To provide support for the ongoing functions of Commissioned Corps members when active Corps members are called away to respond to emergencies, the ACA established a new ***Ready Reserve Corps*** *(Section 5210)*, consisting of personnel who can assist the Regular Corps on short notice for both routine public health and emergency response missions. For each year from FY2010 through FY2014, $17.5 million was authorized for recruitment and training, and to support the Ready Reserve Corps, although no funds have been appropriated to date.

Many public health departments struggle to maintain a sufficient and adequately trained laboratory and epidemiological workforce, and functional, up-to-date equipment. The law expanded the National All-Hazards Preparedness for Public Health Emergencies program by adding the ***Epidemiology and Laboratory Capacity Grants*** *(Section 4304)* program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.

The law expanded the National All-Hazards Preparedness for Public Health Emergencies program by adding the *Epidemiology and Laboratory Capacity Grants* (Section 4304) program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.

tional epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers. The ACA authorized $190 million per year for FY2010 through FY2013. In FY2010 and FY2011, $20 million and $40 million, respectively, from the Prevention and Public Health Fund supported state, local, and tribal epidemiology and laboratory capacity grants.[40,41] The President's FY2012 budget requests $40 million for the program.

The ACA also created new grant programs to support community health workers and school-based health centers. The ***Grants to Promote the Community Health Workforce*** *(Sections 5313, 10501(c))* is a new CDC program that would award grants to states, health departments, health clinics, hospitals, or community health centers to promote positive health behaviors in underserved communities through the use of community health workers, defined as local individuals who promote health or nutrition in culturally and linguistically appropriate ways, and serve as liaisons between communities and health care agencies. Such sums as necessary were authorized for FY2010 through FY2014, however no funds have been appropriated to date. To increase access to clinical preventive services for children, grants for the construction and operation of ***School-Based Health Centers*** were authorized (Section 4101). The construction grants were appropriated mandatory funds ($50 million each year from FY2010 through 2013). However, the operation grants rely on discretionary funding. They were authorized as such sums as necessary and have not yet received funding.

C. NEW PUBLIC HEALTH PROGRAMMING

The ACA created several new programs to promote local community health and prevent chronic disease which will require a trained workforce. The two main community prevention activities, in terms of funding, are the ***Maternal, Infant, and Early Childhood Home Visiting*** *(Section 2951)* program and the Community Transformation Grants. The ACA created the Maternal, Infant, and Early Childhood Home Visiting program to reduce infant and maternal mortality by enhancing prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, and family economic self-sufficiency. The program is based on previous research on home visiting, which demonstrates positive social and health benefits for expectant and new parents.[42] Like the provision governing the National Health Service Corps, this provision differs from many of the other prevention provisions in the ACA in that it includes mandatory funding. Mandatory funding for the Home Visiting program will total $1.5 billion over the next five years; the first $88 million in grants were released in July 2010.[43] The President's FY2012 budget would provide $329 million to award 56 state and territorial grants and funding for technical assistance, $10.5 million for 18 awards to American Indian tribes, and $10.5 million for research, evaluation, and corrective action technical assistance for states not meeting the benchmarks established by the legislation.

Community Transformation Grants (Section 4201) (CTGs) support evidence-based, community-based activities to promote health and prevent chronic diseases, for example by promoting smoking cessation and prevention, or enhancing access to healthy food and physical activity. The CTG program is similar to the Communities Putting Prevention to Work (CPPW) grants, which were included in the American Recovery and Reinvestment Act (ARRA) in 2009.44 The CTG is a discretionary program, but it has received funding from the Prevention and Public Health Fund – $145 million in FY2011.41 In May 2011, the program announced $100 million in funding to support 75 Community Transformation Grants. The President's FY2012 budget requests $221 million for the CTG program.

D. HEALTH WORKFORCE ANALYSIS AND PLANNING

Numerous public health organizations and researchers have drawn attention to the need for better data about the

The Community Transformation Grants, along with other public health programs funded by the ACA, will require trained public health workers to be implemented successfully.

size, composition, and needs of the public health workforce, both to assess current and projected supply, and to develop workforce planning and training activities.[3,10,25,45] The lack of information and research regarding workforce capacity, shortages, and effective development strategies is recognized across the health workforce generally, and three provisions in the ACA are designed to gather and assess data to enable the workforce to meet the population's health needs. The law created a ***National Health Care Workforce Commission*** *(Sections 5101, 10501(a))* tasked to review the health workforce supply and demand, and to make recommendations on national priorities and policies regarding the recruitment, retention, and training of the health workforce, including public health. The Commission is composed of 15 experts in the health workforce field, appointed by the Comptroller General of the Government Accountability Office (GAO). Beginning in 2011, reports on national priorities and policies are due to Congress and the Administration on Oct. 1 of each year, and reports on high-priority topics are due April 1 of each year. The members of the National Health Care Workforce Commission were appointed on Sept. 30, 2010; however, the Commission to date has not received funding and therefore has not been able to meet. The President's FY2012 budget requests $3 million in funding for the Commission.

Secondly, through the ***Health Care Workforce Program Assessment*** *(Section 5103)*, the ACA codified the National Center for Health Workforce Analysis at the Health Resources and Services Administration (HRSA) and established State and Regional Centers for Health Workforce Analysis. The National Center conducts research on health workforce needs and evaluates federal health care workforce programming, particularly with regard to the Title VII programs described above, and administers the ***State Health Care Workforce Development Grants*** *(Section 5102)*, a new competitive health workforce development grants program. Grants support and enable state partnerships to plan and implement activities leading to comprehensive health workforce development strategies at the state and local levels. In FY2010 and 2011, $5 million of the Prevention and Public Health Fund was awarded to State Workforce Development Grants, which HRSA used to fund 25 states to begin comprehensive planning activities and one state (Virginia) to implement its health care workforce plan.[46] Some of these funds went to support public health workforce research projects at the CDC's two research centers dedicated to the public health workforce: the Center of Excellence in Public Health Workforce Research and Policy at the University of Kentucky's College of Public Health, established in 2008; and the Center of Excellence in Public Health Workforce Studies at the University of Michigan School of Public Health, established in 2009.[47] These efforts will help create a procedure to enumerate the public health workforce that eventually can be scaled to a national level—an important first step in assessing the current public health workforce and identifying gaps and needs. The President's FY2012 budget requests $20 million for the National Center for Health Workforce Analysis and $51 million for State Health Workforce Development Grants in 2012.

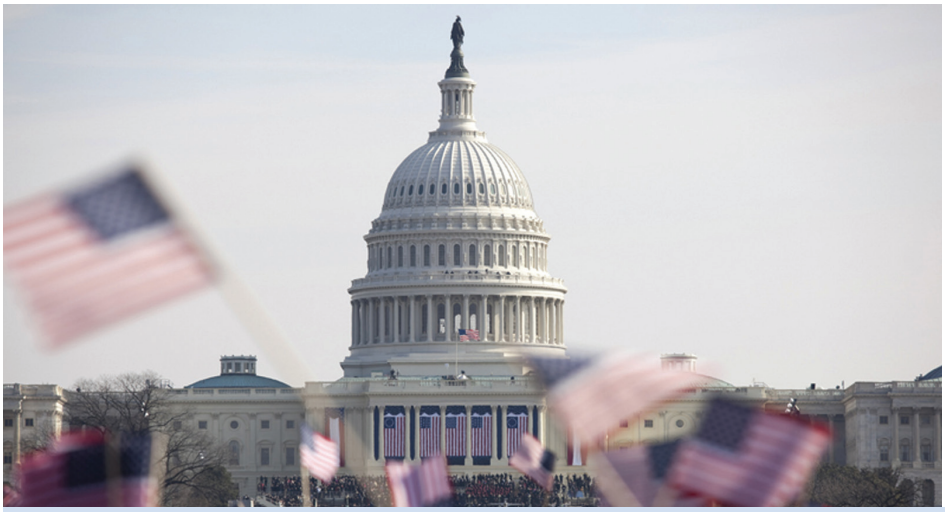
IV. Funding

The health workforce provisions in the ACA have the potential to address the training, recruitment, retention, informational, and worker supply needs facing the public health workforce, particularly at governmental health agencies. The ACA's workforce provisions use a combination of loan repayment, scholarship, fellowship, research, and programming strategies to support existing and new public health and health care workers in a variety of disciplines. However, fulfilling the promise of the ACA's workforce provisions, as with the other parts of the law, depends on whether the law remains intact or is modified, and to what extent its provisions are funded. If fully funded, the ACA's public health and clinical health care workforce provisions would bolster the size and training of the health workforce, and research would produce a better picture of the size, composition, and needs of that workforce. Furthermore, if fully funded, the

Public health workforce research efforts funded by the ACA will help create a procedure to enumerate the public health workforce that eventually can be scaled to a national level—an important first step in assessing the current public health workforce and identifying gaps and needs.

new and expanded public health programming and infrastructure programs would provide an important opportunity to support sustained community-based health promotion and disease prevention activities.

However, prospects for full funding of the ACA's workforce provisions are dim. With the exception of the National Health Service Corps and the Maternal, Infant, and Early Childhood Home Visiting Program, the public health and health care workforce provisions of the ACA are only authorized, meaning they must receive discretionary funds each year through the congressional appropriations process. Unfortunately, the scarcity of resources has prevented the full funding of the workforce and public health programming provisions included in the ACA. To date only 11 of the 19 provisions described in this document have received funding. Of the five public health workforce-specific training programs described above, only two have received funding: the Preventive Medicine and Public Health Training Grant Program and the Public Health Fellowships Program received $33.8 million in FY2010 and $54.6 million in FY2011. Four of these five programs had specific authorization of appropriation lines for FY2010 (vs. "such sums as necessary"). If funded to these authorized levels, these programs would have received a total of $307.5 million; thus, the funds they have received so far are substantially below recommended levels. Seven programs, the Public Health Workforce Loan Repayment Program, the Mid-Career Training Grants, the U.S. Public Health Sciences Track, the Primary Care Extension Program, the Ready Reserve Corps, the Grants to Support Community Health Workers, and the National Health Care Workforce Commission, have not received any funding to date, although funds are requested to support the Commission in the President's FY2012 budget.



Fulfilling the promise of the ACA's workforce provisions, as with the other parts of the law, depends on whether the law remains intact or is modified, and to what extent its provisions are funded.

Most of the funding that has been appropriated for these workforce provisions has come from the ***Prevention and Public Health Fund*** *(Sections 4002, 10401)*, a new mandatory funding stream created by the ACA to expand and sustain investments in prevention and public health programs. The law allocated $500 million to the Fund in FY2010, and gradually increases that amount each year, topping out at $2 billion per year in FY2015 and every year thereafter. Of the $500 million appropriated for the Fund for FY2010, $320 million was used by the Administration to support the health workforce. Controversially, $227 million of the $320 million went to support clinical primary care workforce development, including physician residencies and nurse education,[46,48] despite recommendations by public health groups to focus on public health activities.[49] Nonetheless, $93 million of the $320 was spent on public health workforce training and capacity: $8 million was used to expand the CDC's Public Health Fellowships program, $15 million supported Public Health Training Centers, $20 million went towards the Epidemiology and Laboratory Capacity Grants, and $50 million was used to support performance improvement capacity building in state, local, tribal and territorial health departments through a new CDC initiative entitled the National Public Health Improvement Initiative (NPHII). Of the $750 million allocated to the Fund in FY2011, $125 million is being used to support public health capacity and training, including $40.2 million for CDC's state and local performance improvement capacity efforts, $45 million for public health training initiatives (preventive medi-

The ACA's new Prevention and Public Health Fund has provided key funding for public health and primary care workforce training and support, $320 million in FY10 and $125 million in FY12. However, using the Fund to backfill cuts to public health programs will defeat the purpose of the Fund.

cine fellowships, the Public Health Training Centers, and the Public Health Fellowships program), and $40 million for the Epidemiology and Laboratory Capacity grants. [41] In his FY2012 budget proposal, President Obama requested that $120 million of the $1 billion in mandatory funds from the Prevention and Public Health Fund be allocated to workforce training and capacity: $25 million would support the CDC's public health workforce training programs, $40 million would support Epidemiology and Laboratory Capacity Grants, $40.2 million were requested to support public health infrastructure, and $15 million would support the preventive medicine residency program. The remainder of the Fund monies each year is being used for public health programming and research, which also indirectly supports the public health workforce by sustaining or creating jobs. For example in FY2011 a total of $298 million was allocated to community-based prevention programming, including $145 million for the Community Transformation Grants, and $133 million to research and tracking initiatives.

While the Prevention and Public Health Fund provides a much needed dedicated and stable source of funding for public health, it is a highly controversial element of the Affordable Care Act and vulnerable to political attacks. Starting within months of the passage of the ACA, bills were introduced in Congress proposing to eliminate or defund it, or use it for non-public health purposes. And the Fund continues to be a target for such attacks, either on its own or along with other parts of the ACA. For example, in March 2011, the Health Subcommittee of the House Energy and Commerce Committee held a hearing on changing all mandatory funding in the ACA—including funding for the Prevention and Public Health Fund, NHSC, and home visiting funds—to discretionary funding, which would then be subject to the appropriations process each year.[51] The loss of mandatory funding would be a significant setback to the advances in public health made possible by the ACA.

Even if it is not defunded, the promise of the Fund is also threatened by the need to use it to make up for cuts to CDC and HRSA core funding. Given the current fiscal crisis, most federal agencies, including health agencies, face funding reductions. The final FY2011 Continuing Resolution, approved by Congress on April 14, 2011, cut CDC funding compared with FY2010 levels by more than $740 million, and HRSA by $1.2 billion, including a $600 million reduction in funding for community health centers. Furthermore, the President's FY2012 budget proposed cuts to HRSA and to several CDC programs, including the Public Health Emergency Preparedness Grant Program (-$72 million), and eliminates the Preventive Health and Health Services Block Grant and Built Environment program, with the rationale that these activities will be integrated into programs supported by the Prevention and Public Health Fund. Backfilling these programs using the Fund would defeat the intention of creating an additional funding stream to support new, innovative, community-based prevention and public health programs.

V. Conclusion

The Affordable Care Act reauthorized and created several programs that have the potential to increase the supply and training of the public health workforce, as well as increase our understanding of the capacity and needs of the workforce. Several provisions, including the Public Health Workforce Loan Repayment Program, the Mid-career Training Grants, the Epidemiology and Laboratory Capacity Grants, the Fellowship Training in Public Health, the Preventive Medicine and Public Health Training Grants, and the Commissioned Corps and Ready Reserve Corps, are of particular importance as they help alleviate the longstanding workforce shortages and training needs of governmental public health agencies. However, to date, only some of these

Together, research and advocacy efforts can provide policymakers with evidence that demonstrates the cost-effectiveness of prevention efforts.

provisions have received funding. Most of the health workforce programs that have mandatory funding or have received discretionary funds target the clinical health care workforce; only two of the five programs aimed at training public health workers have received funds, and one of these, the preventive medicine residency program, trains physicians. Although clinicians constitute an important part of the public health workforce, and coordination and cooperation between public health care workers and clinical health care providers is vital in promoting health and preventing disease, there are many other public health professionals who have received less support. With the fiscal situation only worsening, the future funding situation of the ACA's health promotion provisions is very unclear. Public health workers help to create healthier communities —ones with adequate access to preventive health services, healthy food options at school and work, and a well-educated and prepared workforce to respond to emerging population health threats and natural disasters. This is a central part of the vision of the ACA. Sustained, adequate funding is needed to make this vision a reality. Together, research and advocacy efforts can provide policymakers with evidence that demonstrates the cost-effectiveness of prevention efforts, and that funding public health workforce training and capacity is, along with education and transportation infrastructure, a key investment future that will pave the way for our nation's future growth and prosperity.

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11. Training Impact Task Force Report

Council on Linkages Between Academia and Public Health Practice (Council on Linkages)

Training Impact Task Force FACT SHEET
July 2011

Council on Linkages Strategic Directions 2011-2015

Objective B: *Enhance public health practice-oriented education and training*
Strategy 2: *Encourage ongoing training of public health professionals and capture lessons learned and impact*
Tactics: *Explore methods for enhancing and measuring the impact of training*

Task Force Purpose

Identify methods and tools to improve and measure the impact of training

Task Force Deliverables

1) Literature search and summary of themes
2) Identification of methods and tools to improve and measure the impact of training
3) Short document to assist organizations improve and measure the impact of training:
   - Checklists on how to support training preparation (trainee and trainer), and improve training delivery
   - Tools and tips to measure training impact (e.g., short- and long-term post training survey questions, sample surveys)

Roles and Responsibilities of Task Force Members

- Provide expert guidance and direction
- Review and react to draft documents and deliverables
- Meet up to six times via conference calls
- Provide an estimated 6 hours of monthly assistance (includes meetings)

Draft Timeline

Date	Activities
July 2011	Finalize Task Force Members
Aug 2011	Convene first Task Force Meeting
Sept-Nov 2011	Monthly Task Force Meetings via conference call
Dec 2011	No Task Force Meeting
Jan 2012	Present Task Force first draft of deliverables via conference call
Feb 2012	Receive Task Force feedback on deliverables
Mar 2012	Provide final draft of Task Force deliverables via e-mail
April 2012	Finalize deliverables and send to Task Force
May 2012	Present deliverables to full Council on Linkages (Task Force Chair)
June 2012	Receive feedback/comments from Council on Linkages
July 2012	Prepare final documents and send to Council on Linkages

The Council on Linkages Between Academia and Public Health Practice

Training Impact Task Force Member Update

July 28, 2011

Recruitment and selection of Training Impact Task Force (Task Force) members has been underway since March, and formal invitations are expected to be sent out by the end of July. In mid-March, Council on Linkages Between Academia and Public Health Practice (Council) member organizations were asked to recommend individuals with the desired Task Force expertise. A follow-up round of emails went out to a subset of Council members by mid-May along with reminder phone calls. An impressive 22 names were received by the end of May. In June, biographical information was reviewed and research conducted on the nominees. To assure Task Force membership has a well-rounded set of perspectives as it engages in its work, focus areas of expertise were created. The focus areas are: curriculum development, training evaluation, return on investment (ROI) and organizational capacity building, and public health workforce. Along with considering focus areas, the Chair reviewed nominees' experience, field of discipline, and publications relevant to the project, and has selected 10 individuals to serve on the Task Force. The size of the Task Force is being limited to 10 members so that all individuals have ample opportunity to participate during conference call meetings. Staff is in the process of contacting individuals selected to serve on the Task Force to confirm their willingness and availability to serve. It is anticipated that the first Task Force conference call meeting will be held in late August or early September.