The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice

Conference Call Meeting

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Monday, August 15, 2016
1:00-3:00 pm EDT

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Call Number: 1.888.619.1583
Passcode: 479585

Funding provided by the Centers for Disease Control and Prevention

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Staffed by the Public Health Foundation

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Activities of the Council on Linkages Between Academia and Public Health Practice (Council on Linkages) are made possible through funding from the Centers for Disease Control and Prevention under Cooperative Agreement Number U38OT000211. The content of Council on Linkages activities are solely the responsibility of the Council on Linkages and do not necessarily represent the official views of the sponsor.

1. Meeting Agenda

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice
Conference Call Meeting
Date: Monday, August 15, 2016
Time: 1:00-3:00pm EDT
Call Number: 1.888.619.1583
Passcode: 479585#

AGENDA

1:00-1:05	Welcome, Overview of Agenda, and Introduction of New Representatives ➢ Susan Swider (AACN) ➢ Christina Dokter (NALBOH)	*Bill Keck*
1:05-1:10	Approval of Minutes from January 11, 2016 Meeting ➢ **Action Item**: Vote on Approval of Minutes	*Bill Keck*
1:10-1:20	Request for Council Membership – Association for Community Health Improvement (Council Administrative Priorities – Membership) ➢ **Action Item:** Vote on Membership Request	*Julia Resnick*
1:20-1:30	CDC Update (Council Administrative Priorities – Funding)	*Teresa Daub, Pat Drehobl*
1:30-2:10	Council Strategic Directions, 2016-2020 ➢ Council Future Directions and Impact ➢ **Action Item**: Vote on Adoption of Strategic Directions	*Bill Keck*
2:10-2:40	Healthy People (Council Strategic Directions – B.1.d.)	*Liza Corso*
2:40-2:50	Academic Health Department Research Agenda (Council Strategic Directions – A.1.a.)	*Bill Keck*
2:50-2:55	Update on Other Council Activities (Council Strategic Directions – A.1.a, B.1.b., C.1.a, C.3.a.) ➢ Academic Health Department Learning Community ➢ Core Competencies for Public Health Professionals ➢ Recruitment and Retention	*Bill Keck*
2:55-3:00	Other Business and Next Steps	*Bill Keck*
3:00	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:

Susan Swider, PhD, APHN-BC
American Association of Colleges of Nursing

Beverly Taylor, MD
American College of Preventive Medicine

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

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

Philip Amuso, PhD
Association of Public Health Laboratories

Lynn Goldman, MD, MS, MPH
Association of Schools and Programs of Public Health

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

Christopher Atchison, MPA
Association of University Programs in Health Administration

Pat Drehobl, RN, MPH
Centers for Disease Control and Prevention

Barbara Gottlieb, MD
Community-Campus Partnerships for Health

Laura Rasar King, MPH, MCHES
Council on Education for Public Health

Sarah Linde, MD
Health Resources and Services Administration

Beth Ransopher, RS, MEP
National Association of County and City Health Officials

Christina Dokter, MA, PhD
National Association of Local Boards of Health

Carolyn Harvey, PhD
National Environmental Health Association

Lisa Lang, MPP
National Library of Medicine

Patrick Lenihan, PhD
National Network of Public Health Institutes

Louis Rowitz, PhD
National Public Health Leadership Development Network

Susan Little, MSN, RN, APHN-BC, CPHQ
Quad Council Coalition of Public Health Nursing Organizations

Vincent Francisco, PhD
Society for Public Health Education

3. Draft Meeting Minutes – January 11, 2016

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice Conference Call Meeting

Date: January 11, 2016

Meeting Minutes – Draft

Members Present: C. William Keck (Chair), Philip Amuso, Chris Atchison, Pat Drehobl, Terry Dwelle, Vince Francisco, Gary Gilmore, Lisa Lang, Amy Lee, Patrick Lenihan, Sarah Linde, Susan Little, Beth Ransopher, Beverly Taylor, Marlene Wilken

Other Participants Present: Ellen Alkon, Katie Amaya, Karlene Baddy, Roxanne Beharie, Val Carlson, Teresa Daub, Ashley Edmiston, Bobbie Erlwein, Nadim Haddad, Elizabeth Harper, Regina Hutchins, Ty Kane, Eric Kasowski, Rita Kelliher, Laura Rasar King, David Knapp, Kirk Koyama, Vanessa Lamers, Jessie Legros, Bryn Manzella, Carol McDonald, Jennifer McKeever, Melissa Moore, Sarah Neal, Jessica Pittman, Janet Place, Connie Russell, Lisa Sedlar, Dorothy Sekowski, Silvia Shin, Jolynn Socano, Joan Stanley, Leslie Stribling, Susan Swider, Kristen Varol, Sandra Whitehead, Nancy Wittmer

Staff Present: Ron Bialek, Kathleen Amos, Janelle Nichols

Agenda Item	Discussion	Action
Welcome, Overview of Agenda, and Introduction of New Representatives ➢ **Lynn Goldman (ASPPH)** ➢ **Pat Drehobl (CDC)**	The meeting began with a welcome by Council Chair C. William Keck, MD, MPH. Roll call was conducted. Dr. Keck reviewed the agenda for the meeting. Dr. Keck welcomed and introduced two new Council representatives: Lynn Goldman, MD, MS, MPH, for the Association of Schools and Programs of Public Health (ASPPH), and Pat Drehobl, RN, MPH, for the Centers for Disease Control and Prevention (CDC). Susan Little, MSN, RN, APHN-BC, CPHQ, representative for the Quad Council of Public Health Nursing Organizations (Quad Council), shared the organizational changes occurring within the Quad Council. These changes include a name change to the Quad Council Coalition of Public Health Nursing Organizations, and an expanding membership, with the National Association of School Nurses being the first additional organization to join.	
Approval of Minutes from August 10, 2015 Meeting ➢ **Action Item: Vote on approval of minutes**	Dr. Keck asked for any changes to the minutes of the August 10, 2015 Council meeting. Gary Gilmore, MPH, PhD, MCHES, moved to approve the minutes as written. Terry Dwelle, MD, MPH, seconded the motion. No additions or corrections.	Minutes of the August 10, 2015 Council meeting were approved as written.
Request for Council Membership – Council on Education for Public Health	Dr. Keck informed the Council that the Council on Education for Public Health (CEPH) has requested to join the Council. Dr. Keck welcomed Laura Rasar King, MPH, MCHES,	CEPH was granted preliminary Council membership.

➢ **Action Item: Vote on membership request**	Executive Director, CEPH, to speak on behalf of CEPH. Dr. Keck asked for discussion on granting preliminary membership to CEPH. Dr. Gilmore moved to grant preliminary membership. Vince Francisco, PhD, seconded the motion.	
Developing Council Strategic Directions, 2016-2020 ➢ **Council Strategic Directions, 2011-2015** ➢ **Process for Reviewing and Refreshing Strategic Directions**	Dr. Keck provided an overview of the process for refreshing the Council's *Strategic Directions* for 2016-2020. Activities of the Council are guided by the Council's *Strategic Directions*. Over the past five years, the Council has made progress related to activities within each of the objective areas and administrative priorities outlined in its *Strategic Directions, 2011-2015*. The *Strategic Directions, 2011-2015* were developed through a strategic planning process in early 2011, adopted in June 2011, revised in April 2014 following a mid-point review, and were in effect through December 2015. To ensure that the Council's work continues to meet ongoing and emerging needs within the public health community, the *Strategic Directions* are being reviewed and refreshed for 2016-2020. An initial review has been completed by the Council Chair and staff based on the current public health environment and activities of the Council, and suggested revisions have been drafted. Following this meeting, Council staff will be contacting all Council member organizations individually for input on the *Strategic Directions* and will use that input to draft *Strategic Directions* for 2016-2020. That draft will be shared with the Council for review, and revisions will be made as needed. A final draft will be produced and provided to the Council for approval and adoption. The process is anticipated to be completed by the end of June 2016.	Comments or questions about the process for refreshing the *Strategic Directions* may be sent to Kathleen Amos at kamos@phf.org. Council staff will contact Council member organizations to discuss the *Strategic Directions*.
Core Competencies for Public Health Professionals ➢ **Usage of the Core Competencies and Related Resources** ➢ **Healthy People 2020 Data Collection**	Core Competencies Workgroup Co-Chair Janet Place, MPH, provided an update on Core Competencies resources and tools and usage of the Core Competencies and related tools and resources. Since the release of the 2014 Core Competencies, the Core Competencies Workgroup has focused on developing resources and tools to support public health professionals and organizations in using the Core Competencies. The most recent resource completed is a crosswalk of the 2014 Core Competencies and the Essential Public Health Services, which was released in October 2015. The collections of Core Competencies-based	Examples of job descriptions and workforce development plans that incorporate the Core Competencies and other examples of Core Competencies use can be sent to Janelle Nichols at jnichols@phf.org.

	job descriptions and workforce development plans and examples of how public health organizations have used the Core Competencies continue to be enhanced. Additional resources to add to these collections are welcome. Other Core Competencies resources and tools available through the Council website include archived webinars, videos highlighting the Core Competencies, a set of Frequently Asked Questions, a crosswalk of the 2014 and 2010 versions of the Core Competencies, and a set of competency assessments, among other items. Many of these resources and tools were featured in a presentation at the 2015 American Public Health Association (APHA) Annual Meeting. The Core Competencies and related resources and tools are widely used, and this usage is highlighted by the frequency with which these resources are accessed through the Council website. These resources remain among the most accessed items on the Public Health Foundation's website and are the most popular Council items available online. Since the June 2014 release of the current version of the Core Competencies, the Core Competencies have been accessed nearly 71,000 times and resources and tools have been accessed more than 130,000 times. Responding to questions about the Core Competencies has also become a significant part of the work that is done to support usage of the Core Competencies. New Core Competencies resources and tools will be shared through the *Council on Linkages Update*. Dr. Keck thanked all for their assistance with and willingness to collaborate to produce and share these resources and tools. Core Competencies Workgroup Co-Chair Amy Lee, MD, MPH, MBA, provided an update on Healthy People 2020 data collection activities. Within *Healthy People 2020*, the Core Competencies are incorporated into three objectives in the Public Health Infrastructure topic area, one of which is to: "Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula." The Council serves as the data source for this objective, and previously collected data for an equivalent objective in *Healthy People 2010* by working	Council staff will provide information about new Core Competencies resources and tools through the *Council on Linkages Update*.

	with member organizations to reach out to academic institutions. Since the August 2015 Council meeting, when it was reported that work on this activity was on hold as funding was not available, the Council has received funding from CDC's Center for Surveillance, Epidemiology, and Laboratory Services (CSELS) to pursue this activity, and the data collection instrument that will be used has been finalized. Discussions have begun with several Council member organizations about engaging academic institutions, with an aim of initiating data collection by the end of March.	
Discipline-specific Competencies	Dr. Keck provided an overview of the discipline-specific competencies initiatives Council staff are involved in. The Core Competencies have been a major initiative of the Council for over two decades. During this time, Council staff have assisted numerous organizations in developing and refining discipline-specific competencies that are aligned with the Core Competencies. More recently, requests for assistance from Council staff with competencies development, refinement, and implementation have increased, as have requests for Council review of new sets of discipline-specific competencies. Council staff are currently involved in efforts related to competencies for public health laboratorians, public health professionals working with people with disabilities, and community health workers. In addition, CDC has requested Council involvement in developing two new sets of competencies: 1) Competencies for Performance Improvement Professionals; and 2) Population Health Competencies for Hospitals and Health Systems. The Competencies for Performance Improvement Professionals will help articulate desired skills and competencies for individuals working primarily in health departments who have responsibility for quality improvement, performance management, accreditation, and related activities. The Population Health Competencies are being designed for individuals in healthcare settings who have responsibility for population health work in communities. Part of CDC's funding for the Council is being used for these initiatives. CDC's Ms. Drehobl, CSELS; Eric Kasowski, DVM, MD, MPH, FACPM, CSELS; and Bobbie Erlwein, MPH, Office for State, Tribal, Local and Territorial Support, spoke about these two	

	new competencies development efforts, the importance of these types of competencies, and why CDC is interested in and supporting these efforts.	
Academic Health Department Learning Community ➢ **Recent Activities** ➢ **AHD Research Agenda**	Academic Health Department (AHD) Learning Community Chair Dr. Keck provided an update on the Learning Community. The Learning Community has grown to approximately 550 members. In June 2015, the Learning Community launched the AHD Mentorship Program. Led by Bryn Manzella, MPH, Jefferson County Department of Health (AL), this mentorship program aims to foster AHDs by building ongoing relationships between individuals involved in AHD efforts, connecting individuals seeking guidance related to AHD development or operation with those who have experience or expertise in those areas. Learning Community members have volunteered to serve as mentors through this program, mentor/mentee matches are being created, and mentoring is occurring. Positive feedback has been received from current participants, with mentor/mentee pairs discussing a variety of topics. Additional participation in this program is welcome. The Learning Community continues to hold webinar meetings, with the most recent meeting being in January 2016 and focusing on examples of successful AHD partnerships in Kansas and Kentucky. The archive of this meeting will be accessible through the Council website and TRAIN. The Learning Community listserv continues to provide a means for communication within the Learning Community, and work continues to enhance access to Learning Community activities and resources. The idea of developing a research agenda focused on AHD partnerships proposed by Dr. Francisco during the August 2015 Council meeting is the newest initiative of the Learning Community. Efforts to develop an AHD Research Agenda have begun and are being led by Learning Community member Paul Campbell Erwin, MD, DrPH, University of Tennessee Department of Public Health. Once an initial draft is completed, it will be shared with the Learning Community for review and feedback. A final draft will be produced and presented to the Council for review and approval. Information about this activity will be shared through the Learning Community listserv and the *Council on Linkages Update* as the project develops.	Anyone interested in participating in the AHD Mentorship Program as a mentor or mentee can email Janelle Nichols at jnichols@phf.org. Questions about the AHD Research Agenda may be sent to Kathleen Amos at kamos@phf.org. Council staff will provide information about the AHD Research Agenda through the AHD Learning Community listserv and *Council on Linkages Update*.

	The ASPPH-sponsored Academic Public Health Caucus has issued a call for abstracts for the 2016 APHA Annual Meeting, which includes as a topic area "Building the Evidence Base for AHD Partnerships." Abstracts related to this topic are encouraged and can be submitted through APHA's website. Dr. Dwelle and Ms. Manzella spoke about the importance of AHD partnerships and the Learning Community to the broad public health community and their respective health departments, including in achieving accreditation through the Public Health Accreditation Board.	
Update on Other Council Initiatives ➢ **Recruitment and Retention Survey Report** ➢ **2015 APHA Annual Meeting**	Dr. Keck provided an update on the Council's recruitment and retention survey report, noting that data collected through the Council's survey of public health workers in 2010 continue to be shared, and additional analyses of these data have been conducted with researchers at Tulane University. Papers written as a result of this work have been accepted for publication in the *American Journal of Public Health* and the *Journal of Public Health Management and Practice*. A full report of the survey findings is also being prepared for release through the Council website. A draft of this report is expected to be available online in early 2016. Council Director Ron Bialek, MPP, shared highlights of the 2015 APHA Annual Meeting panel session, *Navigating the Seas of Public Health Workforce Development: What Do Practitioners and Academics Need to Know?* Moderated by Dr. Keck and featuring speakers Ms. King, CEPH; Donna Petersen, ScD, MHS, CPH, ASPPH's Framing the Future Task Force; and Edward Hunter, MA, de Beaumont Foundation, this session addressed how national public health workforce development initiatives are aligned. The session was well attended with exceptional participant engagement.	
Other Business and Next Steps	Dr. Keck asked if there was any other business to address. Dr. Keck shared that CEPH is currently in the process of revising the accreditation criteria for graduate-level programs and thanked Council members and others for providing comments to CEPH on its proposed accreditation criteria revisions. Comments on draft revised criteria were accepted through January 8, 2016. Additional public comment periods are	

	expected, and Council members are encouraged to provide feedback to CEPH. Kristen Varol, MPH, CHES, CEPH, shared that CEPH's Board of Councilors will meet to review the comments submitted, with a new draft of the revised criteria expected in February 2016. Comments on this draft will be accepted through mid-May 2016 and again reviewed by the Board of Councilors. An additional round of comments is anticipated in summer 2016. Dr. Keck shared details about CDC's Public Health Associate Program (PHAP), a two-year, paid training and development program that provides opportunities for recent graduates to gain experience in the day-to-day operations of public health programs. State, tribal, local, and territorial public health agencies; community-based organizations; public health institutes and associations; academic institutions; and CDC quarantine stations are encouraged to apply to host a PHAP associate. The application period for host sites is open through January 22, 2016. The next meeting of the Council has not been scheduled, but will likely be held by webinar or conference call. Council staff will be in contact to schedule that meeting.	Council staff will schedule the next Council meeting.

4. **Request for Council Membership – Association for Community Health Improvement:**
    - **Membership Request from the Association for Community Health Improvement**
    - **Council Membership Request – Association for Community Health Improvement Information**

The Council on Linkages Between Academia and Public Health Practice

Membership Request from the Association for Community Health Improvement

August 15, 2016

Overview

The Association for Community Health Improvement (ACHI) is requesting preliminary membership in the Council on Linkages Between Academia and Public Health Practice (Council). ACHI's membership request is included in the meeting materials, and additional information about ACHI is available on its website at http://www.healthycommunities.org/.

Action Item: Vote on Membership Request

During this meeting, a vote will be held to determine whether to grant ACHI preliminary membership in the Council. As a reminder, an organization granted preliminary membership will serve as a preliminary member of the Council for a period of one year, at which time a vote will be held to determine whether to grant the organization full membership status. Each Council member organization has one vote, and this vote must be cast by the organization's official Council representative or designee.

Association for Community Health Improvement's Request to Join the Council on Linkages Between Academia and Public Health Practice

Background

As the United States health care system transforms toward a population health paradigm, hospitals and health care systems are recognizing that in order to improve the health of the communities they serve they need to work collaboratively to address the social determinants of health. Regulations in the Affordable Care Act, namely value-based payment models and the community health needs assessment (CHNA) requirement, are providing the infrastructure and impetus for hospitals to more actively engage in community health improvement initiatives in partnership with multi-sector community stakeholders, namely public health and community development organizations. As the community health field becomes more sophisticated in its approach, standards and best practices are emerging from a variety of research disciplines to support the most effective approaches to improve community health.

Who We Are

The Association for Community Health Improvement (ACHI) is the premier national association dedicated to helping health leaders expand their knowledge and enhance their performance in achieving community health goals. A personal membership group of the American Hospital Association, ACHI advances healthy communities by providing education, professional development and peer networking opportunities to support community benefit, community health and population health professionals from across the US.

In existence since 2002, ACHI has more than 1,000 members from across the country. While our core membership are community benefit professionals from hospitals and health care systems, ACHI also has members from state hospital associations, public health and community development organizations, consulting companies and academic institutions. ACHI aims to cultivate a society of professionals who apply their specialized knowledge and expertise to effectively educate and collaborate with their communities in achieving the highest potential health for community residents. We are driven by our values of collaboration, equity, excellence, innovation and integrity in all our efforts. ACHI receives guidance from a 16-person Advisory Council made up of community health leaders from across the country.

What We Do

The heart of ACHI's work is the support we provide our members as they work toward achieving their community health improvement goals. Since ACHI's membership is diverse in the roles and sectors in which they work, we strive to provide content that will appeal to a wide audience and showcase collaborative approaches to community health improvement. Each year, ACHI hosts 7-10 webinars on a rage of community health issues, produces 2-4 guidance reports and sends bi-weekly newsletters to the membership. ACHI provides ongoing engagement opportunities for members through volunteer participation in committees focused on planning and execution of the educational curriculum, the annual conference and membership recruitment and retention. To view archives of ACHI's webinars or read the guides, visit www.healthycommunities.org.

The annual national conference is ACHI's flagship event. Held every year in early March, the three day national conference has consistently grown over the past thirteen years to host over 600 attendees. The multi-sectoral scope of the ACHI conference positions the meeting as a convener in connecting the work of community health, population health and public health. Breakout sessions are the core component of the conference and feature community health improvement efforts of teams from across the US. Our grassroots approach for soliciting proposals to present at the conference affords us the opportunity to select presentations that address the scope of approaches hospitals and their community partners are using to address community health needs. Conference participants have the unique opportunity to network with their colleagues from across the country to gain insights that support their work. The ACHI conference fosters the opportunity for hospitals and diverse health professionals to collaborate and learn from one another as they work toward achieving the highest potential of health in their communities. To learn more about the ACHI National Conference, visit www.healthycommunities.org/achi2017.

Through its affiliation with the Health Research and Educational Trust, ACHI supports numerous grant-funded projects. Current projects include:

- A learning collaborative for outstanding hospital-community partnerships
- Developing a searchable website database of all community health needs assessments
- Creating a model for patient and community engagement in CHNAs
- Updating the Community Health Assessment Toolkit to reflect advances in CHNA practices

As a division of the American Hospital Association, ACHI is at the forefront of hospital-based community health improvement efforts nationally. Our placement in a major national association enables ACHI to continuously strengthen connections with health care and community health leaders to expand our reach and raise awareness about the crucial role of hospitals and health care systems in improving community health.

Council on Linkages Membership

ACHI would be honored to join the prestigious organizations on the Council on Linkages Between Academia and Public Health Practice. As the only organization whose core constituency is health care organizations, ACHI could provide a unique voice and perspective of the health care field. We would value the opportunity to help link public health research results with hospital-based community health practice. Additionally, serving on the Council would also further ACHI's goal to be more closely connected with our colleagues in national-level public health organizations as we work toward our shared goal – healthier people in healthier communities. We appreciate your consideration for membership.

5. Council Strategic Directions, 2016-2020:

- **Proposed Council Strategic Directions, 2016-2020**
- **Draft Council Strategic Directions, 2016-2020**

The Council on Linkages Between Academia and Public Health Practice

Proposed Council *Strategic Directions, 2016-2020*

August 15, 2016

Overview

Activities of the Council on Linkages Between Academia and Public Health Practice (Council) are guided by the Council's Strategic Directions. Over the past five years, the Council has made progress related to activities within each of the objective areas and administrative priorities outlined in its *Strategic Directions, 2011-2015*. During the Council's January 11, 2016 meeting, an initial set of suggested revisions to the Strategic Directions for 2016-2020 was presented based on the current public health environment and activities of the Council. Following the meeting, calls were held with all 21 Council member organizations to hear and discuss suggestions for changes to the Council's Strategic Directions. A tremendous THANK YOU to each Council member organization for the thoughtful and extremely constructive comments and suggestions provided during and following these conversations.

Developing New Strategic Directions

Input from Council member organizations has provided both specific suggestions about individual objectives, strategies, and tactics within the Strategic Directions, as well as overarching themes about the Council's goals and activities and the way the Council presents its collective work and accomplishments. Council member organizations commented that when the Council was established more than 20 years ago, linkages were an excellent end in and of themselves; however, today, an even greater value and purpose of the Council is as a convener and facilitator of discussions to generate consensus around important public health workforce development needs and ways to address these needs. An overarching theme that came out of these discussions is that the Council is focused on helping to improve the performance of individuals and organizations in public health, with a specific focus on the workforce. Council members recommended substantial changes to the way the Council presents its goals and its work, in order to reflect this important overarching theme.

Based on the discussions with Council member organizations, the draft *Strategic Directions, 2016-2020* was developed and circulated for review, comments, and suggestions. Comments received were incorporated into a second draft for further discussion and a vote on adoption during the August 15, 2016 Council meeting.

Action Item: Vote on Adoption of Strategic Directions, 2016-2020

The current draft *Strategic Directions, 2016-2020* is included in the meeting materials and will be presented to the Council for additional discussion and a vote on adoption. As a reminder, each Council member organization has one vote, and this vote must be cast by the organization's official Council representative or designee. Once adopted, the *Strategic Directions, 2016-2020* will guide the Council's work through 2020.

The Council on Linkages Between Academia and Public Health Practice

Strategic Directions, 2016-2020

Draft #2: July 2016

Mission

To improve the performance of individuals and organizations within public health by:

- Fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities;
- Promoting public health education and training for health professionals throughout their careers; and
- Developing and advancing innovative strategies to build and strengthen public health infrastructure.

Values

- Teamwork and Collaboration
- Focus on the Future
- People and Partners
- Creativity and Innovation
- Results and Creating Value
- Health Equity
- 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 diverse, highly skilled, and motivated public health workforce with the competence and tools to succeed.
- Promote and strengthen the evidence base for public health practice.

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 academia and practice within public health.

Tactics:

a. Support the development, maintenance, and expansion of academic health department partnerships through the Academic Health Department Learning Community.
b. Document and highlight progress being made in academic/practice collaboration within public health and the impact of that collaboration.
c. Document contributions of Council on Linkages member organizations, individually and collectively, to improving public health performance through implementation of the Council on Linkages' Strategic Directions.

d. Coordinate with other national initiatives, such as the Foundational Public Health Services, public health department and academic institution accreditation, Healthy People, National Consortium for Public Health Workforce Development, Public Health Workforce Interests and Needs Survey (PH WINS), and Health Impact in Five Years (HI-5) initiative, to improve public health performance through implementation of the Council on Linkages' Strategic Directions.

~~d.~~e. Learn from and share with other countries and global health organizations strategies for strengthening the public health workforce.

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

Tactics:

a. Identify population health competencies aligned with the Core Competencies for Public Health Professionals that are designed for non-clinical settings.
b. Encourage the inclusion of healthcare professionals and organizations in academic health department partnerships.
c. Document and highlight progress being made in public health/healthcare collaboration and the impact of that collaboration.

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 and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into education and training.
c. Work with the Council on Education for Public Health to encourage use of the Core Competencies for Public Health Professionals and academic/practice partnerships by schools and programs of public health.
d. Work with the National Board of Public Health Examiners to encourage use of the Core Competencies for Public Health Professionals in the Certified in Public Health credentialing program.
e. Contribute to the development and measurement of Healthy People objectives related to public health infrastructure.
f. Advance opportunities for using the Core Competencies for Public Health Professionals in the education and training of health professionals and other professionals who impact health.

Strategy 2: Encourage development of quality training for public health professionals.

Tactics:

a. Provide resources and tools for enhancing and measuring the impact of training.
b. Contribute to efforts to develop quality standards for public health training.
c. Explore the desirability and feasibility of creating a process for approving and advancing training for general public health continuing education units.

Strategy 3: Promote public health practice-based learning.

Tactics:

a. Conduct a periodic review of practice-based content in public health education.

b. Develop tools to assist academic health departments in providing high quality practica.

Objective C. Support the development of a diverse, 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. Support the use of evidence in recruitment and retention strategies for the public health workforce.
b. Use existing data to better understand the composition and competencies of the public health workforce.
c. Participate in the Public Health Accreditation Board's workforce development, quality improvement, and performance management activities to encourage use of Core Competencies for Public Health Professionals and academic/practice partnerships by health departments.
d. Explore approaches for determining contributions of credentialing for ensuring a competent public health workforce.
e. Participate in, facilitate, and/or convene efforts to develop a national strategic or action 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.

Tactics:

a. Explore emerging leadership competencies needed within the public health workforce for health systems transformation.
b. Identify skills needed for public health professionals to assume the responsibilities of community chief health strategist.

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

Tactics:

a. Develop and disseminate tools and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into practice.
b. Assist individuals and organizations with using tools and training to implement and integrate the Core Competencies for Public Health Professionals into practice.
c. Encourage use of the Core Competencies for Public Health Professionals as a foundation for the development of discipline-specific and interprofessional competencies.
~~c.~~d. Assist with developing, refining, and implementing discipline-specific and interprofessional competencies aligned with the Core Competencies for Public Health Professionals.
~~d. Encourage use of the Core Competencies for Public Health Professionals as a foundation for the development of discipline-specific and interprofessional competencies.~~
e. Assist other countries and global health organizations with developing and using public health competencies.

Strategy 4: Demonstrate the value of public health to achieving a c~~C~~ulture of h~~H~~ealth.

Tactics:

a. Document contributions of the various professions within public health to achieving healthy communities.
b. Describe the unique contributions that public health professionals can bring to health systems transformation.
c. Encourage public health professionals to engage other professions and sectors in developing strategies for achieving healthy communities.
d. Document how public health research can and does contribute to achieving healthy communities.
e. Participate in, facilitate, and/or conduct a profile study of the public health workforce.

Objective D. Promote and strengthen the evidence base for public health practice.

Strategy 1: Support efforts to further public health practice research, including public health systems and services research (PHSSR).

Tactics:

a. Identify gaps in data and opportunities for improving data for conducting research relevant to practice.
b. Identify emerging needs for public health practice research to support health systems transformation.
c. Collaborate with other national efforts to help build capacity for and promote public health practice research.
d. Convene potential funders to increase financial support for public health practice research.
e. Assess progress related to public health practice research.

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

Tactics:

a. Identify ways to ~~solicit and~~ disseminate and improve access to evidence-based practices.
b. Demonstrate the value of public health practice research to the practice of public health.
~~b.~~c. Explore opportunities to support The Guide to Community Preventive Services.

Strategy 3: Encourage the engagement of public health practitioners in contributing to the public health evidence base.

Tactics:

a. Develop and support implementation of an academic health department research agenda.
b. Foster the development, sharing, and use of practice-based evidence.

Council on Linkages Administrative Priorities: *Please note, to keep the focus of the Strategic Directions, 2016-2020 on the direction of the Council on Linkages, the Administrative Priorities have been removed from this document. These priorities remain important to the way administrative support for the Council on Linkages is provided.*

6. Healthy People:

- **Healthy People 2020: Public Health Infrastructure**

Healthy People 2020: Public Health Infrastructure

August 15, 2016

Healthy People at the Forefront of Public Health

1979

1990

2000

2010

1979 Smallpox Eradicated

1970 Clean Air Act

1982 AIDS is Infectious

1988 SG Declares Nicotine Addictive

1990 Human Genome Project Begins

1990s Drinking Water Fluoridation

2000s Obesity and Chronic Disease

September 11, 2001

2005 Hurricane Katrina

2009 H1N1 Flu

Evolution of Healthy People

Target Year	1990	2000	2010	2020
Overarching Goals	• Decrease mortality: infants–adults • Increase independence among older adults	• Increase span of healthy life • Reduce health disparities • Achieve access to preventive services for all	• Increase quality and years of healthy life • Eliminate health disparities	• Attain high-quality, longer lives free of preventable disease • Achieve health equity; eliminate disparities • Create social and physical environments that promote good health • Promote quality of life, healthy development, healthy behaviors across life stages
# Topic Areas	15	22	28	42
# Objectives/ Measures	226	312	1,000	~1,200

Healthy People 2020: Public Health Infrastructure Topic Area

HealthyPeople.gov | Healthy People 2020

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Print Share

Public Health Infrastructure

Overview | Objectives | National Snapshots

Goal

To ensure that Federal, State, Tribal, territorial, and local health agencies have the necessary infrastructure to effectively provide essential public health services.

View HP2020 Data for:
► Public Health Infrastructure

Overview

Public health infrastructure provides communities, states, and the Nation the capacity to prevent disease, promote health, and prepare for and respond to both acute (emergency) threats and chronic (ongoing) challenges to health. Infrastructure is the foundation for planning, delivering, evaluating, and improving public health.

Why Is Public Health Infrastructure Important?

All public health services depend on the presence of basic infrastructure. Every public health program—such as immunizations, infectious disease monitoring, cancer and asthma prevention, drinking water quality, injury prevention—requires health professionals who are competent in cross-cutting and technical skills, up-to-date information systems, and public health organizations with the capacity to assess and respond to community health needs. Public health infrastructure has been referred to as "the nerve center of the public health system."[1]

While a strong infrastructure depends on many organizations, public health agencies (health departments) are considered primary players. Federal agencies rely on the presence of solid public health infrastructure at all levels[2] to support the implementation of public health programs

Healthy People 2020

Public Health Infrastructure

Lead Agencies

- Centers for Disease Control and Prevention – Liza Corso, Senior Advisor, Division of Public Health Performance Improvement, Office of State Territorial and Tribal Support (LCorso@cdc.gov)
- Heath Resources and Services Administration – Emily DeCoster, Public Health Analyst, Office of Research and Evaluation

National Center for Health Statistics

- Health Promotion Statistics Branch - Sirin Yaemsiri, PhD, Epidemiologist (wkq7@cdc.gov)

Office of Disease Prevention and Health Promotion

- Community Strategies Division, Yen Lin, MPH, Public Health Advisor

Healthy People 2020

Current Workforce Objectives PHI 4 and 6

Current Objs	Measure
PHI-4.1	% of 4-yr colleges and universities with public health or related majors
PHI-4.2	% of 4-yr colleges and universities with public health or related minors
PHI-6.1	% of 2-yr colleges with public health or related associate degrees
PHI-6.2	% of 4-yr colleges with public health or related certificate programs

Issues with current objectives:

- Methodology not reproducible
- Measures don't focus well on an end goal— i.e., pipeline or education information (degrees conferred)
- Measures don't include graduate degrees

Healthy People 2020

Proposal for Revising Objectives

Objs	Measure
1	Number of associate's degree or certificates awarded that are public health or related
2	Number of bachelor degrees awarded that are public health or related
3	Number of graduate degrees awarded that are public health or related
Proposed data source: Integrated Postsecondary Education Data System (IPEDS), National Center for Education Statistics	

Healthy People 2020

Proposal, continued

"Public health or related" to be defined based on CIP Codes:

- All categorized as 51.22 Public Health
- All with "See also: 51.22" notes, which include:
  - Epidemiology (26.1309)
  - Health Policy Analysis (44.0503)
  - Dental Public Health and Education (51.0504)

⊖ 51.21) Podiatric Medicine/Podiatry.
  51.2101) Podiatric Medicine/Podiatry.
⊖ 51.22) Public Health.
  51.2201) Public Health, General.
  51.2202) Environmental Health.
  51.2205) Health/Medical Physics.
  51.2206) Occupational Health and Industrial Hygiene.
  51.2207) Public Health Education and Promotion.
  51.2208) Community Health and Preventive Medicine.
  51.2209) Maternal and Child Health.
  51.2210) International Public Health/International Health.
  51.2211) Health Services Administration.
  51.2212) Behavioral Aspects of Health.
  51.2299) Public Health, Other.
⊖ 51.23) Rehabilitation and Therapeutic Professions.

Discussion Opportunities

- Focus of objectives -- is number of degrees conferred an appropriate measure?
- To what extent is type of institution important (e.g., 4-year and 2 year institutions, degree-granting and non-degree granting, private not for profit, private for profit, public)?
- If or where we should include post-baccalaureate certificates? (could this be within 4.1 or should this only be sub-baccalaureate? If only sub-bac, then where could post-baccalaureate certificates best be included?)
- Other questions / feedback?

Healthy People 2020

Development and Input Process

- Ongoing PHI Team conversations
- Conversations and data from AAC&U
- Internal conversations and input within CDC (OSTLTS and CSELS)
- Outreach to select subject matter experts
- Department of Education IPEDS – review of definitions and data
- **Council on Linkages Between Academia and Public Health Practice**
  - **Consortium of national organizations focused on public health workforce**
- TBD: Department of Education IPEDS data team
- TBD: Healthy People 2020 Federal Interagency Workgroup

Healthy People 2020

Stay Connected

Join the Healthy People Listserv & Consortium

Web	healthypeople.gov
Email	healthypeople@hhs.gov
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LinkedIn	Healthy People 2020
YouTube	ODPHP (search “healthy people”)

7. Academic Health Department Research Agenda:

- **Academic Health Department Research Agenda Report**
- **Draft Academic Health Department Research Agenda**

The Council on Linkages Between Academia and Public Health Practice

Academic Health Department Research Agenda Report

August 15, 2016

Overview

Following a discussion during the August 2015 Council on Linkages Between Academia and Public Health Practice (Council) meeting, the Academic Health Department (AHD) Learning Community launched a new initiative to develop a research agenda focused on the AHD model. This research agenda explores questions related to measuring the value of AHD partnerships in enhancing public health and determining best practices critical to partnership success, and suggests opportunities for collaborative research on the structure, functions, and impacts of AHDs.

Led by AHD Learning Community member Paul Campbell Erwin, MD, DrPH, of the University of Tennessee Department of Public Health, a small team including Ross Brownson, PhD, George Warren Brown School of Social Work and School of Medicine, Washington University in St. Louis; Scott Frank, MD, MS, Case Western Reserve University School of Medicine; and William Livingood, PhD, University of Florida College of Medicine – Jacksonville, produced an initial draft of the research agenda in January 2016. This draft was shared with the AHD Learning Community by webinar in March 2016 to begin gathering feedback and made available on the Public Health Foundation's (PHF's) website for public comment. Requests for feedback were distributed through the AHD Learning Community; *Council on Linkages Update*; *PHF E-News*; National Network of Public Health Institutes' weekly newsletter for the Public Health Training Centers; University of Kentucky's Systems for Action National Coordinating Center newsletter, which reaches the Public Heath Practice-Based Research Networks and broader public health systems and services research community; and social media.

Feedback received was used to revise the AHD Research Agenda to produce a final draft for review and approval by the Council. This draft is included in the meeting materials. The Council is encouraged to provide comments on the draft research agenda during this meeting, as well as by email to Kathleen Amos at kamos@phf.org through August 31, 2016. Comments received will be addressed, and a Council vote on approval of the final AHD Research Agenda will be held by email.

A Proposed Research Agenda for the Academic Health Department

Draft: January 2016

Revised July 26, 2016

Paul C. Erwin, MD, DrPH
Ross C. Brownson, PhD
Scott H. Frank, MD, MS
William C. Livingood, PhD

In November 2016, Dr. Bill Keck and Ms. Kathleen Amos, representing the Council on Linkages (COL) between Academia and Public Health Practice, asked one of us (Paul Erwin) if he would be willing to lead an effort to draft a research agenda for the Academic Health Department (AHD). During this discussion, names of other public health experts who might also contribute were suggested, and a potential process and timeline were identified.

Subsequent to this meeting Drs Ross Brownson, Scott Frank, and Bill Livingood were invited to participate in this process. The goal, purpose, and methods are outlined below:

Goal: Provide a substantive draft of an AHD Research Agenda to the Council on Linkages by February 1, 2016

Purpose: To formulate strategies to build support (funding and otherwise) for collaborative research on the structure, functions, and impacts of AHDs

Methods and Timeline: As a starting point, the group used the "Example Research and Evaluation Questions for the Academic Health Department" published in A Logic Model for Evaluating the Academic Health Department (Erwin et al, *J Public Health Manag Pract*. 2015 Feb 26). These initial potential research questions were framed around a logic model, shown below. Between November 2015 and January 2016, the group held three conference calls, with each call focused on a specific aspect of the logic model framework for research questions. After each call, revisions were circulated to the group, with additional input provided. Following the final scheduled call on January 25, 2016, a final draft Research Agenda was circulated.

In this final report we do not include questions that are – at face value – unanswerable, but we have included questions that may push the research methodologies and that may even require new systems of surveillance be established that can allow new measurements to be tracked. We envision this as a "first generation" research agenda (i.e., other investigators may place these proposed research questions into different logic model topics than what we have outlined below or they will likely have additional potential research questions).

Logic Model for the Academic Health Department (Erwin et al, *J Public Health Manag Pract*. 2015 Feb 26)

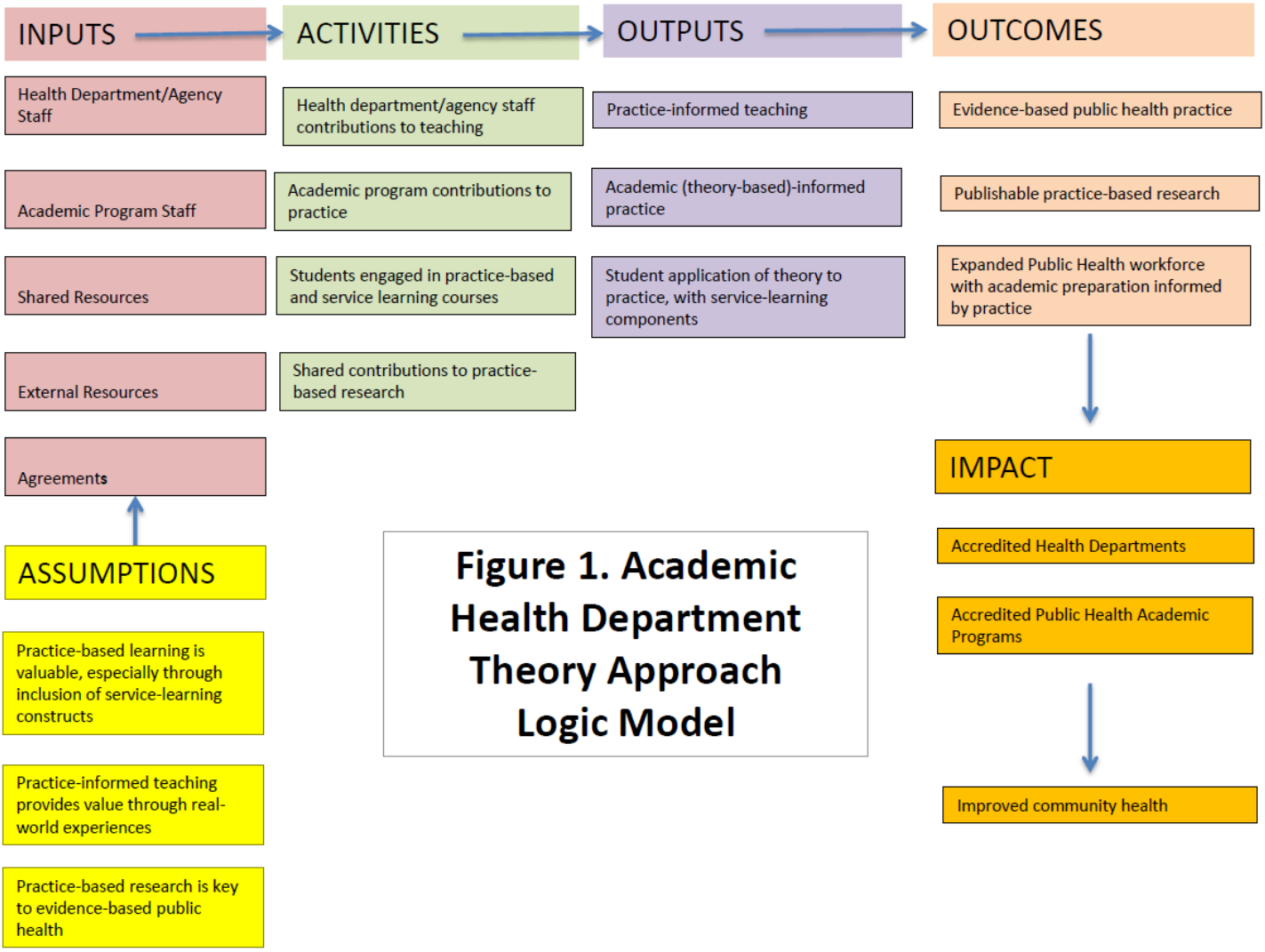


Figure 1. Academic Health Department Theory Approach Logic Model

A Proposed Research Agenda for the Academic Health Department

Logic Model Parameter	Potential Research Questions
Inputs	1. What models and theories of education and training are most effective in creating the conditions to establish AHDs?
	2. How do practitioners and academicians in settings with AHD partnerships differ from practitioners and academicians in settings without AHD partnerships in terms of background, training, and expertise?
	3. What are the critical resources and organizational environments for establishing AHDs? What is the variability across AHDs in resources, and how does such variability matter?
	4. What is the value of shared personnel in AHDs?
	5. Which types of personnel contribute most to AHDs?
	6. What are the types of formal agreements that have been used to establish AHDs, and what are the critical elements of such agreements?
	7. How do the prevailing attitudes about practice and academia differ in settings with AHD partnerships vs. settings without AHD partnerships? Do these attitudes influence the ability to establish and maintain AHDs?
	8. Are students in AHD settings better prepared to apply what they are learning in the classroom to the practice setting while they are still students? Are they better prepared after graduating?
	9. Are academic and practice organizations prepared to jointly develop data for enhancing teaching, research, and practice?
Activities	1. What value do AHDs add to service-learning courses?
	2. What are the mechanisms by which academicians contribute to program development, implementation, and evaluation in the practice setting?
	3. What are the mechanisms by which practitioners contribute to development, implementation, and evaluation of education and research in the academic setting?

	4. What are the ways in which AHDs facilitate practice-based research?
	5. Do AHDs enhance the quality and relevance of student field placements (internships), and if so, how?
	6. What are the roles that AHDs have in Accountable Care Organizations?
	7. What are the roles that AHDs have in addressing the social determinants of health, and in particular, health inequities?
	8. What are the roles that AHDs have in successful implementation of state and federal community benefit requirements?
Outputs	1. Do students in settings with AHD partnerships exhibit greater skill and competence in the Core Competencies for Public Health Professionals than students in settings without AHD partnerships?
	2. Does the presence of academicians impact the development of evidence-based practices in ways that are more effective and efficient in settings with AHD partnerships than settings without AHD partnerships?
	3. Are students in AHD settings more capable of civic engagement?
	4. How do AHDs enhance translating research into practice?
	5. How can AHDs inform the field of dissemination and implementation science?
	6. Do AHDs lead to more and better partnerships (beyond the AHD partnership itself)?
	7. Does being engaged in AHD activities enhance the “standing” of academicians and practitioners in their fields?
	8. Does having faculty engaged through AHD partnerships enhance delivery of essential public health services, and if so, how?
	9. Does having practitioners engaged through AHD partnerships enhance public health education, and if so, how?
	10. Does having practitioners engaged through AHD partnerships enhance public health research, and if so, how?

	11. What is the impact of AHDs on the development and delivery of academic curriculum?
	12. What is the impact of AHDs on the development and delivery of public health services?
	13. Does involvement of practitioners in the classroom impact their practice?
	14. Does involvement of faculty in practice settings impact their teaching?
	15. Do AHD partners publish their work in peer-reviewed journals, in textbooks, or in other ways?
	16. Do AHD partnerships enhance the effectiveness of public health practice in advocating or defending policies before local or state legislative or oversight bodies?
Outcomes	1. Do health departments participating in AHD partnerships implement evidence-based practices to a greater degree than health departments that do not participate in AHD partnerships?
	2. Are students in AHD settings more successful in obtaining employment?
	3. Are health departments that hire students with experience in AHD settings more satisfied with their new employees compared to new hires without this experience?
	4. Are health departments that participate in AHD partnerships more successful in achieving accreditation through the Public Health Accreditation Board (PHAB) than health departments that do not participate in AHD partnerships?
	5. Are academic programs that participate in AHD partnerships more successful in achieving accreditation through the Council on Education for Public Health (CEPH) than academic programs that do not participate in AHD partnerships?
	6. Will AHDs that involve medical students and residents serve as models for patient-centered primary care?
	7. What is the return on investment for AHDs, from both the academic and practice perspectives?
	8. What is the impact of AHD partnerships on the skills and decision-making processes of health department leaders?

	9. What is the impact of AHD partnerships on the skills and decision-making processes of academic institution leaders?
	10. What is the impact of AHD partnerships on the organizational climate and culture of health departments?
	11. What is the impact of AHD partnerships on the organizational climate and culture of academic institutions?
	12. Do health departments with AHD partnerships demonstrate more effective financial allocation strategies?
	13. Do health departments with AHD partnerships perform better than those without AHD partnerships in assuring delivery of essential public health services to their communities?
	14. What are the critical elements for sustaining AHD partnerships?
	15. Do AHD partnerships enhance workforce development and training for public health practice?
Impact	1. Do AHD partnerships facilitate the achievement of the mission of the public health practice organization – assuring conditions in which people can be healthy?
	2. Do AHD partnerships facilitate the mission of the academic institution?
	3. Does the presence of AHD partnerships have a greater impact on community health improvement activities and outcomes than not having AHD partnerships?

8. Update on Other Council Activities:

- **Update on Council Activities**
- **Core Competencies for Public Health Professionals (2014)**
- **Use of the Core Competencies for Public Health Professionals in Academia: Results of Healthy People 2020 Data Collection**
- **Recruitment and Retention: What's Influencing the Decisions of Public Health Workers**

The Council on Linkages Between Academia and Public Health Practice

Update on Council Activities

August 15, 2016

Overview

The Council on Linkages Between Academia and Public Health Practice (Council) engages in a variety of activities that support workforce development for the public health workforce. To date in 2016, progress has been made in a number of areas, including the Academic Health Department (AHD) Learning Community, Core Competencies for Public Health Professionals (Core Competencies), and recruitment and retention.

Academic Health Department Learning Community

The AHD Learning Community supports development of AHD partnerships between public health practice organizations and academic institutions. As a national community of practitioners, educators, and researchers, the AHD Learning Community stimulates discussion and sharing of knowledge; the development of resources; and collaborative learning around establishing, sustaining, and expanding AHDs. The Learning Community currently has approximately 600 members.

Recent Activities

AHD Learning Community meetings continue to be held on an ongoing basis, with three meetings in 2016 focusing on sharing examples of AHD partnerships in Kansas, Kentucky, and Alabama, as well as on developing a research agenda to explore questions related to the structure, functions, and impacts of AHDs. Additional Learning Community meetings are being planned for later this year. The list of AHD partnerships compiled by the Learning Community continues to grow, as does the collection of partnership agreements used to formalize AHD relationships. Contributions for these resources are always welcome by email to Kathleen Amos at kamos@phf.org.

The AHD Mentorship Program, which formally launched at the end of June 2015, also continues to develop. This program helps to foster AHDs by building relationships between individuals involved in AHD efforts. Led by Bryn Manzella, MPH, of the Jefferson County Department of Health (AL), the mentorship program connects individuals seeking guidance in an area of AHD development or operation with those having experience in that area, with a focus on creating ongoing relationships that support mutual learning and professional development. Participation in the program is growing, with eight existing mentor/mentee matches, and additional matches continuing to be created. Expressions of interest in participating as either a mentor or mentee are welcome by email to Janelle Nichols at jnichols@phf.org.

Core Competencies for Public Health Professionals

The Core Competencies reflect foundational skills desirable for professionals engaged in the practice, education, and research of public health and are used in education, training, and other workforce development activities across the country. The Core Competencies and related resources and tools are widely used within health departments, academic institutions, and other public health organizations, and this usage is highlighted by the frequency with which these resources are accessed through the Council website. Since the June 2014 release of the current version of the Core Competencies, the Core Competencies have been accessed nearly 96,000 times, and tools and resources have been accessed more than 178,000 times.

Resources and Tools
Since the release of the 2014 version of the Core Competencies, work has continued to develop resources and tools to support public health professionals and organizations in using the Core Competencies. Most recently, descriptions of the eight Core Competencies domains and a summary showing how the Core Competencies are used to support health department accreditation and performance improvement were created. Efforts have also focused on expanding collections of workforce development plans and job descriptions that incorporate the Core Competencies. These collections now include 24 workforce development plans and 25 job descriptions that are provided as examples for others who are developing their own. Additional examples that can be added to either of these collections, other resources and tools to support use of the Core Competencies, or expressions of interest in the Core Competencies Workgroup are welcome by email to Janelle Nichols at jnichols@phf.org.

Healthy People 2020 Data Collection
Within *Healthy People 2020*, the Core Competencies are incorporated into three objectives in the Public Health Infrastructure (PHI) topic area. The Council serves as the data source for the third of these objectives, PHI-3: *Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula*, and worked with three Council member organizations to collect data related to this objective in 2016. Of the academic institutions that provided information, 92% indicated that they have used the Core Competencies. A full summary of results of this data collection is included in the meeting materials.

Recruitment and Retention
In 2010, the Council conducted a survey to explore recruitment and retention within the US public health workforce. This survey considered factors that influenced individuals' decisions to take and remain in jobs in the public health field, as well as their satisfaction with elements of the environments in which they worked, including organizational leadership, management, and professional development. Nearly 12,000 individuals shared their experiences through this survey, and the results of this exploration are now summarized in the Council's report, *Recruitment and Retention: What's Influencing the Decisions of Public Health Workers?* A copy of this report is included in the meeting materials. In addition, the dataset containing responses from the individuals on which these results are based is available for further research. More information about accessing this data can be obtained online or by contacting Kathleen Amos at kamos@phf.org.

The Council on Linkages Between Academia and Public Health Practice

June 2014

Core Competencies for Public Health Professionals

Revised and Adopted by the Council on Linkages Between Academia and Public Health Practice:
June 26, 2014

Available from: phf.org/corecompetencies

Council on Linkages Between Academia and Public Health Practice

The Council on Linkages Between Academia and Public Health Practice (Council on Linkages) is a collaborative of 20 national organizations that aims to improve public health education and training, practice, and research. Established in 1992 to implement the recommendations of the Public Health Faculty/Agency Forum regarding increasing the relevance of public health education to the practice of public health, the Council on Linkages works to further academic/practice collaboration to ensure a well-trained, competent workforce and the development and use of a strong evidence base for public health practice.

Mission

The Council on Linkages strives to improve public health practice, education, and research by fostering, coordinating, and monitoring links among academia and the public health practice and healthcare communities; 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.

Membership

Twenty national organizations are members of the Council on Linkages:

- American Association of Colleges of Nursing
- American College of Preventive Medicine
- American Public Health Association
- Association for Prevention Teaching and Research
- Association of Accredited Public Health Programs
- Association of Public Health Laboratories
- Association of Schools and Programs of Public Health
- Association of State and Territorial Health Officials
- Association of University Programs in Health Administration
- Centers for Disease Control and Prevention
- Community-Campus Partnerships for Health
- Health Resources and Services Administration
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- National Environmental Health Association
- National Library of Medicine
- National Network of Public Health Institutes
- National Public Health Leadership Development Network
- Quad Council of Public Health Nursing Organizations
- Society for Public Health Education

The Council on Linkages is funded by the Centers for Disease Control and Prevention. Staff support is provided by the Public Health Foundation.

For More Information

Additional information about the Council on Linkages can be found at phf.org/councilonlinkages. Questions or requests for information may be sent to councilonlinkages@phf.org.

Core Competencies for Public Health Professionals

The Core Competencies for Public Health Professionals (Core Competencies) are a consensus set of skills for the broad practice of public health, as defined by the 10 Essential Public Health Services. Developed by the Council on Linkages Between Academia and Public Health Practice (Council on Linkages), the Core Competencies reflect foundational skills desirable for professionals engaging in the practice, education, and research of public health.

The Core Competencies support workforce development within public health and can serve as a starting point for public health professionals and organizations as they work to better understand and meet workforce development needs, improve performance, prepare for accreditation, and enhance the health of the communities they serve. More specifically, the Core Competencies can be used in assessing workforce knowledge and skills, identifying training needs, developing workforce development and training plans, crafting job descriptions, and conducting performance evaluations. The Core Competencies have been integrated into curricula for education and training, provide a reference for developing public health courses, and serve as a base for sets of discipline-specific competencies.

The Core Competencies provide a framework for workforce development planning and action. Public health organizations are encouraged to interpret and adapt the Core Competencies in ways that meet their specific organizational needs.

Development of the Core Competencies

The Core Competencies grew from a desire to help strengthen the public health workforce by identifying basic skills for the effective delivery of public health services. Building on the Universal Competencies developed by the Public Health Faculty/Agency Forum in 1991, the current Core Competencies are the result of more than two decades of work by the Council on Linkages and other academic and practice organizations dedicated to public health.

Transitioning from a general set of Universal Competencies to a more specific set of Core Competencies began in 1998 and involved public health professionals from across the country through Council on Linkages member organizations, the Council on Linkages' Core Competencies Workgroup, and a public comment period that resulted in over 1,000 comments. This extensive development process was designed to produce a set of foundational competencies that truly reflected the practice of public health. These competencies were organized into eight skill areas or "domains" that cut across public health disciplines. The first version of the Core Competencies was adopted by the Council on Linkages in April 2001, and the Council on Linkages committed to revisiting the Core Competencies every three years to determine if revisions were needed to ensure the continued relevance of the competency set.

The Core Competencies were reviewed in 2004, with the Council on Linkages concluding that there was inadequate evidence about use of the Core Competencies to support a significant revision. At the second review in 2007, the Council on Linkages decided that revision was warranted based on usage data, changes in the practice of public health, and requests to make the Core Competencies more measurable.

Similar to the development process, the revision process begun in 2007 was led by the Core Competencies Workgroup and involved the consideration of more than 800 comments from public health professionals. A major focus of the revision process was on improving measurability of the competencies, and the revisions both updated the content of the competencies within the eight domains and added three "tiers" representing stages of career development for public health professionals. The Council on Linkages adopted a revised version of the Core Competencies in May 2010.

Review of the May 2010 Core Competencies began in early 2013, and the Council on Linkages again decided to undertake revisions. In addition to updating the content of the competencies, this revision process was aimed at simplifying and clarifying the wording of competencies and improving the order and grouping of competencies to make the competency set easier to use. This revision process was guided by the Core Competencies Workgroup and over 1,000 comments from the public health community, and culminated in the adoption by the Council on Linkages of the current set of Core Competencies in June 2014.

Key Dates

Since development began in 1998, the Core Competencies have gone through three versions:

- 2001 version – Adopted April 11, 2001 *(original version)*
- 2010 version – Adopted May 3, 2010
- 2014 version – Adopted June 26, 2014 *(current version)*

Currently, the Core Competencies are on a three year review cycle and will next be considered for revision in 2017. This timing may change as a result of feedback that this can be too frequent for disciplines that base competency sets on the Core Competencies.

Organization of the Core Competencies

The Core Competencies are organized into eight domains, reflecting skill areas within public health, and three tiers, representing career stages for public health professionals.

Domains

- Analytical/Assessment Skills
- Policy Development/Program Planning Skills
- Communication Skills
- Cultural Competency Skills
- Community Dimensions of Practice Skills
- Public Health Sciences Skills
- Financial Planning and Management Skills
- Leadership and Systems Thinking Skills

These eight domains have remained consistent in all versions of the Core Competencies.

Tiers

- *Tier 1 – Front Line Staff/Entry Level.* Tier 1 competencies apply to public health professionals who carry out the day-to-day tasks of public health organizations and are not in management positions. Responsibilities of these professionals may include data collection and analysis, fieldwork, program planning, outreach, communications, customer service, and program support.
- *Tier 2 – Program Management/Supervisory Level.* Tier 2 competencies apply to public health professionals in program management or supervisory roles. Responsibilities of these professionals may include developing, implementing, and evaluating programs; supervising staff; establishing and maintaining community partnerships; managing timelines and work plans; making policy recommendations; and providing technical expertise.
- *Tier 3 – Senior Management/Executive Level.* Tier 3 competencies apply to public health professionals at a senior management level and to leaders of public health organizations. These professionals typically have staff who report to them and may be responsible for overseeing major programs or operations of the organization, setting a strategy and vision for the organization, creating a culture of quality within the organization, and working with the community to improve health.

During the 2014 revision of the Core Competencies, minor changes were made to clarify these tier definitions. In general, competencies progress from lower to higher levels of skill complexity both within each domain in a given tier and across the tiers. Similar competencies within Tiers 1, 2, and 3 are presented next to each other to show connections between tiers. In some cases, a single competency appears in multiple tiers; however, the way competence in that area is demonstrated may vary from one tier to another.

Core Competencies Resources and Tools

A variety of resources and tools to assist public health professionals and organizations with using the Core Competencies exist or are under development. These include crosswalks of different versions of the Core Competencies, competency assessments, examples demonstrating attainment of competence, competency-based job descriptions, quality improvement tools, and workforce development plans. Core Competencies resources and tools can be found online at phf.org/corecompetenciestools. Examples of how organizations have used the Core Competencies are available at phf.org/corecompetenciesexamples.

Feedback on the Core Competencies

The Council on Linkages thanks the public health community for its tremendous contributions to the Core Competencies and welcomes feedback about the Core Competencies. Examples illustrating how public health professionals and organizations are using the Core Competencies and tools that facilitate Core Competencies use are also appreciated. Feedback, suggestions, and resources can be shared by emailing competencies@phf.org.

For More Information

Additional information about the Core Competencies, including background on development and revisions, resources and tools to facilitate use, and current activities and events, can be found at phf.org/aboutcorecompetencies. Questions or requests for information may be sent to competencies@phf.org.

Analytical/Assessment Skills		
Tier 1	**Tier 2**	**Tier 3**
1A1. Describes factors affecting the health of a community (e.g., equity, income, education, environment)	1B1. Describes factors affecting the health of a community (e.g., equity, income, education, environment)	1C1. Describes factors affecting the health of a community (e.g., equity, income, education, environment)
1A2. Identifies quantitative and qualitative data and information (e.g., vital statistics, electronic health records, transportation patterns, unemployment rates, community input, health equity impact assessments) that can be used for assessing the health of a community	1B2. Determines quantitative and qualitative data and information (e.g., vital statistics, electronic health records, transportation patterns, unemployment rates, community input, health equity impact assessments) needed for assessing the health of a community	1C2. Determines quantitative and qualitative data and information (e.g., vital statistics, electronic health records, transportation patterns, unemployment rates, community input, health equity impact assessments) needed for assessing the health of a community
1A3. Applies ethical principles in accessing, collecting, analyzing, using, maintaining, and disseminating data and information	1B3. Applies ethical principles in accessing, collecting, analyzing, using, maintaining, and disseminating data and information	1C3. Ensures ethical principles are applied in accessing, collecting, analyzing, using, maintaining, and disseminating data and information
1A4. Uses information technology in accessing, collecting, analyzing, using, maintaining, and disseminating data and information	1B4. Uses information technology in accessing, collecting, analyzing, using, maintaining, and disseminating data and information	1C4. Uses information technology in accessing, collecting, analyzing, using, maintaining, and disseminating data and information
1A5. Selects valid and reliable data	1B5. Analyzes the validity and reliability of data	1C5. Evaluates the validity and reliability of data
1A6. Selects comparable data (e.g., data being age-adjusted to the same year, data variables across datasets having similar definitions)	1B6. Analyzes the comparability of data (e.g., data being age-adjusted to the same year, data variables across datasets having similar definitions)	1C6. Evaluates the comparability of data (e.g., data being age-adjusted to the same year, data variables across datasets having similar definitions)
1A7. Identifies gaps in data	1B7. Resolves gaps in data	1C7. Resolves gaps in data

Analytical/Assessment Skills		
Tier 1	**Tier 2**	**Tier 3**
1A8. Collects valid and reliable quantitative and qualitative data	1B8. Collects valid and reliable quantitative and qualitative data	1C8. Ensures collection of valid and reliable quantitative and qualitative data
1A9. Describes public health applications of quantitative and qualitative data	1B9. Analyzes quantitative and qualitative data	1C9. Determines trends from quantitative and qualitative data
1A10. Uses quantitative and qualitative data	1B10. Interprets quantitative and qualitative data	1C10. Integrates findings from quantitative and qualitative data into organizational plans and operations (e.g., strategic plan, quality improvement plan, professional development)
1A11. Describes assets and resources that can be used for improving the health of a community (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs)	1B11. Identifies assets and resources that can be used for improving the health of a community (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs)	1C11. Assesses assets and resources that can be used for improving the health of a community (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs)
1A12. Contributes to assessments of community health status and factors influencing health in a community (e.g., quality, availability, accessibility, and use of health services; access to affordable housing)	1B12. Assesses community health status and factors influencing health in a community (e.g., quality, availability, accessibility, and use of health services; access to affordable housing)	1C12. Determines community health status and factors influencing health in a community (e.g., quality, availability, accessibility, and use of health services; access to affordable housing)
1A13. Explains how community health assessments use information about health status, factors influencing health, and assets and resources	1B13. Develops community health assessments using information about health status, factors influencing health, and assets and resources	1C13. Ensures development of community health assessments using information about health status, factors influencing health, and assets and resources

Analytical/Assessment Skills		
Tier 1	**Tier 2**	**Tier 3**
1A14. Describes how evidence (e.g., data, findings reported in peer-reviewed literature) is used in decision making	1B14. Makes evidence-based decisions (e.g., determining research agendas, using recommendations from *The Guide to Community Preventive Services* in planning population health services)	1C14. Makes evidence-based decisions (e.g., determining research agendas, using recommendations from *The Guide to Community Preventive Services* in planning population health services)
	1B15. Advocates for the use of evidence in decision making that affects the health of a community (e.g., helping policy makers understand community health needs, demonstrating the impact of programs)	1C15. Advocates for the use of evidence in decision making that affects the health of a community (e.g., helping elected officials understand community health needs, demonstrating the impact of programs)

Policy Development/Program Planning Skills		
Tier 1	**Tier 2**	**Tier 3**
2A1. Contributes to state/Tribal/community health improvement planning (e.g., providing data to supplement community health assessments, communicating observations from work in the field)	2B1. Ensures state/Tribal/community health improvement planning uses community health assessments and other information related to the health of a community (e.g., current data and trends; proposed federal, state, and local legislation; commitments from organizations to take action)	2C1. Ensures development of a state/Tribal/community health improvement plan (e.g., describing measurable outcomes, determining needed policy changes, identifying parties responsible for implementation)
2A2. Contributes to development of program goals and objectives	2B2. Develops program goals and objectives	2C2. Develops organizational goals and objectives
2A3. Describes organizational strategic plan (e.g., includes measurable objectives and targets; relationship to community health improvement plan, workforce development plan, quality improvement plan, and other plans)	2B3. Contributes to development of organizational strategic plan (e.g., includes measurable objectives and targets; incorporates community health improvement plan, workforce development plan, quality improvement plan, and other plans)	2C3. Develops organizational strategic plan (e.g., includes measurable objectives and targets; incorporates community health improvement plan, workforce development plan, quality improvement plan, and other plans) with input from the governing body or administrative unit that oversees the organization
2A4. Contributes to implementation of organizational strategic plan	2B4. Implements organizational strategic plan	2C4. Monitors implementation of organizational strategic plan
2A5. Identifies current trends (e.g., health, fiscal, social, political, environmental) affecting the health of a community	2B5. Monitors current and projected trends (e.g., health, fiscal, social, political, environmental) representing the health of a community	2C5. Integrates current and projected trends (e.g., health, fiscal, social, political, environmental) into organizational strategic planning

Policy Development/Program Planning Skills		
Tier 1	**Tier 2**	**Tier 3**
2A6. Gathers information that can inform options for policies, programs, and services (e.g., secondhand smoking policies, data use policies, HR policies, immunization programs, food safety programs)	2B6. Develops options for policies, programs, and services (e.g., secondhand smoking policies, data use policies, HR policies, immunization programs, food safety programs)	2C6. Selects options for policies, programs, and services for further exploration (e.g., secondhand smoking policies, data use policies, HR policies, immunization programs, food safety programs)
2A7. Describes implications of policies, programs, and services	2B7. Examines the feasibility (e.g., fiscal, social, political, legal, geographic) and implications of policies, programs, and services	2C7. Determines the feasibility (e.g., fiscal, social, political, legal, geographic) and implications of policies, programs, and services
	2B8. Recommends policies, programs, and services for implementation	2C8. Selects policies, programs, and services for implementation
2A8. Implements policies, programs, and services	2B9. Implements policies, programs, and services	2C9. Ensures implementation of policies, programs, and services is consistent with laws and regulations
		2C10. Influences policies, programs, and services external to the organization that affect the health of the community (e.g., zoning, transportation routes)
2A9. Explains the importance of evaluations for improving policies, programs, and services	2B10. Explains the importance of evaluations for improving policies, programs, and services	2C11. Explains the importance of evaluations for improving policies, programs, and services
2A10. Gathers information for evaluating policies, programs, and services (e.g., outputs, outcomes, processes, procedures, return on investment)	2B11. Evaluates policies, programs, and services (e.g., outputs, outcomes, processes, procedures, return on investment)	2C12. Ensures the evaluation of policies, programs, and services (e.g., outputs, outcomes, processes, procedures, return on investment)

Policy Development/Program Planning Skills		
Tier 1	**Tier 2**	**Tier 3**
2A11. Applies strategies for continuous quality improvement	2B12. Implements strategies for continuous quality improvement	2C13. Develops strategies for continuous quality improvement
2A12. Describes how public health informatics is used in developing, implementing, evaluating, and improving policies, programs, and services (e.g., integrated data systems, electronic reporting, knowledge management systems, geographic information systems)	2B13. Uses public health informatics in developing, implementing, evaluating, and improving policies, programs, and services (e.g., integrated data systems, electronic reporting, knowledge management systems, geographic information systems)	2C14. Assesses the use of public health informatics in developing, implementing, evaluating, and improving policies, programs, and services (e.g., integrated data systems, electronic reporting, knowledge management systems, geographic information systems)

Communication Skills		
Tier 1	**Tier 2**	**Tier 3**
3A1. Identifies the literacy of populations served (e.g., ability to obtain, interpret, and use health and other information; social media literacy)	3B1. Assesses the literacy of populations served (e.g., ability to obtain, interpret, and use health and other information; social media literacy)	3C1. Ensures that the literacy of populations served (e.g., ability to obtain, interpret, and use health and other information; social media literacy) is reflected in the organization's policies, programs, and services
3A2. Communicates in writing and orally with linguistic and cultural proficiency (e.g., using age-appropriate materials, incorporating images)	3B2. Communicates in writing and orally with linguistic and cultural proficiency (e.g., using age-appropriate materials, incorporating images)	3C2. Communicates in writing and orally with linguistic and cultural proficiency (e.g., using age-appropriate materials, incorporating images)
3A3. Solicits input from individuals and organizations (e.g., chambers of commerce, religious organizations, schools, social service organizations, hospitals, government, community-based organizations, various populations served) for improving the health of a community	3B3. Solicits input from individuals and organizations (e.g., chambers of commerce, religious organizations, schools, social service organizations, hospitals, government, community-based organizations, various populations served) for improving the health of a community	3C3. Ensures that the organization seeks input from other organizations and individuals (e.g., chambers of commerce, religious organizations, schools, social service organizations, hospitals, government, community-based organizations, various populations served) for improving the health of a community
3A4. Suggests approaches for disseminating public health data and information (e.g., social media, newspapers, newsletters, journals, town hall meetings, libraries, neighborhood gatherings)	3B4. Selects approaches for disseminating public health data and information (e.g., social media, newspapers, newsletters, journals, town hall meetings, libraries, neighborhood gatherings)	3C4. Evaluates approaches for disseminating public health data and information (e.g., social media, newspapers, newsletters, journals, town hall meetings, libraries, neighborhood gatherings)

Communication Skills		
Tier 1	**Tier 2**	**Tier 3**
3A5. Conveys data and information to professionals and the public using a variety of approaches (e.g., reports, presentations, email, letters)	3B5. Conveys data and information to professionals and the public using a variety of approaches (e.g., reports, presentations, email, letters, press releases)	3C5. Conveys data and information to professionals and the public using a variety of approaches (e.g., reports, presentations, email, letters, testimony, press interviews)
3A6. Communicates information to influence behavior and improve health (e.g., uses social marketing methods, considers behavioral theories such as the Health Belief Model or Stages of Change Model)	3B6. Communicates information to influence behavior and improve health (e.g., uses social marketing methods, considers behavioral theories such as the Health Belief Model or Stages of Change Model)	3C6. Evaluates strategies for communicating information to influence behavior and improve health (e.g., uses social marketing methods, considers behavioral theories such as the Health Belief Model or Stages of Change Model)
3A7. Facilitates communication among individuals, groups, and organizations	3B7. Facilitates communication among individuals, groups, and organizations	3C7. Facilitates communication among individuals, groups, and organizations
3A8. Describes the roles of governmental public health, health care, and other partners in improving the health of a community	3B8. Communicates the roles of governmental public health, health care, and other partners in improving the health of a community	3C8. Communicates the roles of governmental public health, health care, and other partners in improving the health of a community

Cultural Competency Skills		
Tier 1	**Tier 2**	**Tier 3**
4A1. Describes the concept of diversity as it applies to individuals and populations (e.g., language, culture, values, socioeconomic status, geography, education, race, gender, age, ethnicity, sexual orientation, profession, religious affiliation, mental and physical abilities, historical experiences)	4B1. Describes the concept of diversity as it applies to individuals and populations (e.g., language, culture, values, socioeconomic status, geography, education, race, gender, age, ethnicity, sexual orientation, profession, religious affiliation, mental and physical abilities, historical experiences)	4C1. Describes the concept of diversity as it applies to individuals and populations (e.g., language, culture, values, socioeconomic status, geography, education, race, gender, age, ethnicity, sexual orientation, profession, religious affiliation, mental and physical abilities, historical experiences)
4A2. Describes the diversity of individuals and populations in a community	4B2. Describes the diversity of individuals and populations in a community	4C2. Describes the diversity of individuals and populations in a community
4A3. Describes the ways diversity may influence policies, programs, services, and the health of a community	4B3. Recognizes the ways diversity influences policies, programs, services, and the health of a community	4C3. Recognizes the ways diversity influences policies, programs, services, and the health of a community
4A4. Recognizes the contribution of diverse perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of a community	4B4. Supports diverse perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of a community	4C4. Incorporates diverse perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of a community
4A5. Addresses the diversity of individuals and populations when implementing policies, programs, and services that affect the health of a community	4B5. Ensures the diversity of individuals and populations is addressed in policies, programs, and services that affect the health of a community	4C5. Advocates for the diversity of individuals and populations being addressed in policies, programs, and services that affect the health of a community

Cultural Competency Skills		
Tier 1	**Tier 2**	**Tier 3**
4A6. Describes the effects of policies, programs, and services on different populations in a community	4B6. Assesses the effects of policies, programs, and services on different populations in a community (e.g., customer satisfaction surveys, use of services by the target population)	4C6. Evaluates the effects of policies, programs, and services on different populations in a community
4A7. Describes the value of a diverse public health workforce	4B7. Describes the value of a diverse public health workforce	4C7. Demonstrates the value of a diverse public health workforce
	4B8. Advocates for a diverse public health workforce	4C8. Takes measures to support a diverse public health workforce

Community Dimensions of Practice Skills		
Tier 1	**Tier 2**	**Tier 3**
5A1. Describes the programs and services provided by governmental and non-governmental organizations to improve the health of a community	5B1. Distinguishes the roles and responsibilities of governmental and non-governmental organizations in providing programs and services to improve the health of a community	5C1. Assesses the roles and responsibilities of governmental and non-governmental organizations in providing programs and services to improve the health of a community
5A2. Recognizes relationships that are affecting health in a community (e.g., relationships among health departments, hospitals, community health centers, primary care providers, schools, community-based organizations, and other types of organizations)	5B2. Identifies relationships that are affecting health in a community (e.g., relationships among health departments, hospitals, community health centers, primary care providers, schools, community-based organizations, and other types of organizations)	5C2. Explains the ways relationships are affecting health in a community (e.g., relationships among health departments, hospitals, community health centers, primary care providers, schools, community-based organizations, and other types of organizations)
5A3. Suggests relationships that may be needed to improve health in a community	5B3. Suggests relationships that may be needed to improve health in a community	5C3. Suggests relationships that may be needed to improve health in a community
	5B4. Establishes relationships to improve health in a community (e.g., partnerships with organizations serving the same population, academic institutions, policy makers, customers/clients, and others)	5C4. Establishes relationships to improve health in a community (e.g., partnerships with organizations serving the same population, academic institutions, policy makers, customers/clients, and others)
5A4. Supports relationships that improve health in a community	5B5. Maintains relationships that improve health in a community	5C5. Maintains relationships that improve health in a community
5A5. Collaborates with community partners to improve health in a community (e.g., participates in committees, shares data and information, connects people to resources)	5B6. Facilitates collaborations among partners to improve health in a community (e.g., coalition building)	5C6. Establishes written agreements (e.g., memoranda-of-understanding [MOUs], contracts, letters of endorsement) that describe the purpose and scope of partnerships

Community Dimensions of Practice Skills		
Tier 1	**Tier 2**	**Tier 3**
5A6. Engages community members (e.g., focus groups, talking circles, formal meetings, key informant interviews) to improve health in a community	5B7. Engages community members to improve health in a community (e.g., input in developing and implementing community health assessments and improvement plans, feedback about programs and services)	5C7. Ensures that community members are engaged to improve health in a community (e.g., input in developing and implementing community health assessments and improvement plans, feedback about programs and services)
5A7. Provides input for developing, implementing, evaluating, and improving policies, programs, and services	5B8. Uses community input for developing, implementing, evaluating, and improving policies, programs, and services	5C8. Ensures that community input is used for developing, implementing, evaluating, and improving policies, programs, and services
5A8. Uses assets and resources (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs) to improve health in a community	5B9. Explains the ways assets and resources (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs) can be used to improve health in a community	5C9. Negotiates for use of assets and resources (e.g., Boys & Girls Clubs, public libraries, hospitals, faith-based organizations, academic institutions, federal grants, fellowship programs) to improve health in a community
5A9. Informs the public about policies, programs, and resources that improve health in a community	5B10. Advocates for policies, programs, and resources that improve health in a community (e.g., using evidence to demonstrate the need for a program, communicating the impact of a program)	5C10. Defends policies, programs, and resources that improve health in a community (e.g., using evidence to demonstrate the need for a program, communicating the impact of a program)
5A10. Describes the importance of community-based participatory research	5B11. Collaborates in community-based participatory research	5C11. Engages the organization in community-based participatory research

Public Health Sciences Skills		
Tier 1	**Tier 2**	**Tier 3**
6A1. Describes the scientific foundation of the field of public health	6B1. Discusses the scientific foundation of the field of public health	6C1. Critiques the scientific foundation of the field of public health
6A2. Identifies prominent events in the history of public health (e.g., smallpox eradication, development of vaccinations, infectious disease control, safe drinking water, emphasis on hygiene and hand washing, access to health care for people with disabilities)	6B2. Describes prominent events in the history of public health (e.g., smallpox eradication, development of vaccinations, infectious disease control, safe drinking water, emphasis on hygiene and hand washing, access to health care for people with disabilities)	6C2. Explains lessons to be learned from prominent events in the history of public health (e.g., smallpox eradication, development of vaccinations, infectious disease control, safe drinking water, emphasis on hygiene and hand washing, access to health care for people with disabilities)
6A3. Describes how public health sciences (e.g., biostatistics, epidemiology, environmental health sciences, health services administration, social and behavioral sciences, and public health informatics) are used in the delivery of the 10 Essential Public Health Services	6B3. Applies public health sciences (e.g., biostatistics, epidemiology, environmental health sciences, health services administration, social and behavioral sciences, and public health informatics) in the delivery of the 10 Essential Public Health Services	6C3. Ensures public health sciences (e.g., biostatistics, epidemiology, environmental health sciences, health services administration, social and behavioral sciences, and public health informatics) are applied in the delivery of the 10 Essential Public Health Services
	6B4. Applies public health sciences in the administration and management of programs	6C4. Applies public health sciences in the administration and management of the organization
6A4. Retrieves evidence (e.g., research findings, case reports, community surveys) from print and electronic sources (e.g., PubMed, *Journal of Public Health Management and Practice*, *Morbidity and Mortality Weekly Report*, *The World Health Report*) to support decision making	6B5. Retrieves evidence (e.g., research findings, case reports, community surveys) from print and electronic sources (e.g., PubMed, *Journal of Public Health Management and Practice*, *Morbidity and Mortality Weekly Report*, *The World Health Report*) to support decision making	6C5. Synthesizes evidence (e.g., research findings, case reports, community surveys) from print and electronic sources (e.g., PubMed, *Journal of Public Health Management and Practice*, *Morbidity and Mortality Weekly Report*, *The World Health Report*) to support decision making

Public Health Sciences Skills		
Tier 1	**Tier 2**	**Tier 3**
6A5. Recognizes limitations of evidence (e.g., validity, reliability, sample size, bias, generalizability)	6B6. Determines limitations of evidence (e.g., validity, reliability, sample size, bias, generalizability)	6C6. Explains limitations of evidence (e.g., validity, reliability, sample size, bias, generalizability)
6A6. Describes evidence used in developing, implementing, evaluating, and improving policies, programs, and services	6B7. Uses evidence in developing, implementing, evaluating, and improving policies, programs, and services	6C7. Ensures the use of evidence in developing, implementing, evaluating, and improving policies, programs, and services
6A7. Describes the laws, regulations, policies, and procedures for the ethical conduct of research (e.g., patient confidentiality, protection of human subjects, Americans with Disabilities Act)	6B8. Identifies the laws, regulations, policies, and procedures for the ethical conduct of research (e.g., patient confidentiality, protection of human subjects, Americans with Disabilities Act)	6C8. Ensures the ethical conduct of research (e.g., patient confidentiality, protection of human subjects, Americans with Disabilities Act)
6A8. Contributes to the public health evidence base (e.g., participating in Public Health Practice-Based Research Networks, community-based participatory research, and academic health departments; authoring articles; making data available to researchers)	6B9. Contributes to the public health evidence base (e.g., participating in Public Health Practice-Based Research Networks, community-based participatory research, and academic health departments; authoring articles; making data available to researchers)	6C9. Contributes to the public health evidence base (e.g., participating in Public Health Practice-Based Research Networks, community-based participatory research, and academic health departments; authoring articles; reviewing manuscripts; making data available to researchers)
6A9. Suggests partnerships that may increase use of evidence in public health practice (e.g., between practice and academic organizations, with health sciences libraries)	6B10. Develops partnerships that will increase use of evidence in public health practice (e.g., between practice and academic organizations, with health sciences libraries)	6C10. Maintains partnerships that increase use of evidence in public health practice (e.g., between practice and academic organizations, with health sciences libraries)

Financial Planning and Management Skills		
Tier 1	**Tier 2**	**Tier 3**
7A1. Describes the structures, functions, and authorizations of governmental public health programs and organizations	7B1. Explains the structures, functions, and authorizations of governmental public health programs and organizations	7C1. Assesses the structures, functions, and authorizations of governmental public health programs and organizations
7A2. Describes government agencies with authority to impact the health of a community	7B2. Identifies government agencies with authority to address specific community health needs (e.g., lead in housing, water fluoridation, bike lanes, emergency preparedness)	7C2. Engages governmental agencies with authority to address specific community health needs (e.g., lead in housing, water fluoridation, bike lanes, emergency preparedness)
7A3. Adheres to organizational policies and procedures	7B3. Implements policies and procedures of the governing body or administrative unit that oversees the organization (e.g., board of health, chief executive's office, Tribal council)	7C3. Manages the implementation of policies and procedures of the governing body or administrative unit that oversees the organization (e.g., board of health, chief executive's office, Tribal council)
7A4. Describes public health funding mechanisms (e.g., categorical grants, fees, third-party reimbursement, tobacco taxes)	7B4. Explains public health and health care funding mechanisms and procedures (e.g., categorical grants, fees, third-party reimbursement, tobacco taxes, value-based purchasing, budget approval process)	7C4. Leverages public health and health care funding mechanisms and procedures (e.g., categorical grants, fees, third-party reimbursement, tobacco taxes, value-based purchasing, budget approval process) for supporting population health services
	7B5. Justifies programs for inclusion in organizational budgets	7C5. Determines priorities for organizational budgets
7A5. Contributes to development of program budgets	7B6. Develops program budgets	7C6. Develops organizational budgets
	7B7. Defends program budgets	7C7. Defends organizational budgets

Financial Planning and Management Skills		
Tier 1	**Tier 2**	**Tier 3**
7A6. Provides information for proposals for funding (e.g., foundations, government agencies, corporations)	7B8. Prepares proposals for funding (e.g., foundations, government agencies, corporations)	7C8. Approves proposals for funding (e.g., foundations, government agencies, corporations)
7A7. Provides information for development of contracts and other agreements for programs and services	7B9. Negotiates contracts and other agreements for programs and services	7C9. Approves contracts and other agreements for programs and services
7A8. Describes financial analysis methods used in making decisions about policies, programs, and services (e.g., cost-effectiveness, cost-benefit, cost-utility analysis, return on investment)	7B10. Uses financial analysis methods in making decisions about policies, programs, and services (e.g., cost-effectiveness, cost-benefit, cost-utility analysis, return on investment)	7C10. Ensures the use of financial analysis methods in making decisions about policies, programs, and services (e.g., cost-effectiveness, cost-benefit, cost-utility analysis, return on investment)
7A9. Operates programs within budget	7B11. Manages programs within current and projected budgets and staffing levels (e.g., sustaining a program when funding and staff are cut, recruiting and retaining staff)	7C11. Ensures that programs are managed within current and projected budgets and staffing levels (e.g., sustaining a program when funding and staff are cut, recruiting and retaining staff)
7A10. Describes how teams help achieve program and organizational goals (e.g., the value of different disciplines, sectors, skills, experiences, and perspectives; scope of work and timeline)	7B12. Establishes teams for the purpose of achieving program and organizational goals (e.g., considering the value of different disciplines, sectors, skills, experiences, and perspectives; determining scope of work and timeline)	7C12. Establishes teams for the purpose of achieving program and organizational goals (e.g., considering the value of different disciplines, sectors, skills, experiences, and perspectives; determining scope of work and timeline)
7A11. Motivates colleagues for the purpose of achieving program and organizational goals (e.g., participating in teams, encouraging sharing of ideas, respecting different points of view)	7B13. Motivates personnel for the purpose of achieving program and organizational goals (e.g., participating in teams, encouraging sharing of ideas, respecting different points of view)	7C13. Motivates personnel for the purpose of achieving program and organizational goals (e.g., participating in teams, encouraging sharing of ideas, respecting different points of view)

Financial Planning and Management Skills		
Tier 1	**Tier 2**	**Tier 3**
7A12. Uses evaluation results to improve program and organizational performance	7B14. Uses evaluation results to improve program and organizational performance	7C14. Oversees the use of evaluation results to improve program and organizational performance
7A13. Describes program performance standards and measures	7B15. Develops performance management systems (e.g., using informatics skills to determine minimum technology requirements and guide system design, identifying and incorporating performance standards and measures, training staff to use system)	7C15. Establishes performance management systems (e.g., visible leadership, performance standards, performance measurement, reporting progress, quality improvement)
7A14. Uses performance management systems for program and organizational improvement (e.g., achieving performance objectives and targets, increasing efficiency, refining processes, meeting *Healthy People* objectives, sustaining accreditation)	7B16. Uses performance management systems for program and organizational improvement (e.g., achieving performance objectives and targets, increasing efficiency, refining processes, meeting *Healthy People* objectives, sustaining accreditation)	7C16. Uses performance management systems for program and organizational improvement (e.g., achieving performance objectives and targets, increasing efficiency, refining processes, meeting *Healthy People* objectives, sustaining accreditation)

Leadership and Systems Thinking Skills		
Tier 1	**Tier 2**	**Tier 3**
8A1. Incorporates ethical standards of practice (e.g., Public Health Code of Ethics) into all interactions with individuals, organizations, and communities	8B1. Incorporates ethical standards of practice (e.g., Public Health Code of Ethics) into all interactions with individuals, organizations, and communities	8C1. Incorporates ethical standards of practice (e.g., Public Health Code of Ethics) into all interactions with individuals, organizations, and communities
8A2. Describes public health as part of a larger inter-related system of organizations that influence the health of populations at local, national, and global levels	8B2. Describes public health as part of a larger inter-related system of organizations that influence the health of populations at local, national, and global levels	8C2. Interacts with the larger inter-related system of organizations that influence the health of populations at local, national, and global levels
8A3. Describes the ways public health, health care, and other organizations can work together or individually to impact the health of a community	8B3. Explains the ways public health, health care, and other organizations can work together or individually to impact the health of a community	8C3. Creates opportunities for organizations to work together or individually to improve the health of a community
8A4. Contributes to development of a vision for a healthy community (e.g., emphasis on prevention, health equity for all, excellence and innovation)	8B4. Collaborates with individuals and organizations in developing a vision for a healthy community (e.g., emphasis on prevention, health equity for all, excellence and innovation)	8C4. Collaborates with individuals and organizations in developing a vision for a healthy community (e.g., emphasis on prevention, health equity for all, excellence and innovation)
8A5. Identifies internal and external facilitators and barriers that may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis and other quality improvement methods and tools, problem solving)	8B5. Analyzes internal and external facilitators and barriers that may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis and other quality improvement methods and tools, problem solving)	8C5. Takes measures to minimize internal and external barriers that may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis and other quality improvement methods and tools, problem solving)

Leadership and Systems Thinking Skills		
Tier 1	**Tier 2**	**Tier 3**
8A6. Describes needs for professional development (e.g., training, mentoring, peer advising, coaching)	8B6. Provides opportunities for professional development for individuals and teams (e.g., training, mentoring, peer advising, coaching)	8C6. Ensures availability (e.g., assessing competencies, workforce development planning, advocating) of professional development opportunities for the organization (e.g., training, mentoring, peer advising, coaching)
8A7. Participates in professional development opportunities	8B7. Ensures use of professional development opportunities by individuals and teams	8C7. Ensures use of professional development opportunities throughout the organization
8A8. Describes the impact of changes (e.g., social, political, economic, scientific) on organizational practices	8B8. Modifies organizational practices in consideration of changes (e.g., social, political, economic, scientific)	8C8. Ensures the management of organizational change (e.g., refocusing a program or an entire organization, minimizing disruption, maximizing effectiveness of change, engaging individuals affected by change)
8A9. Describes ways to improve individual and program performance	8B9. Contributes to continuous improvement of individual, program, and organizational performance (e.g., mentoring, monitoring progress, adjusting programs to achieve better results)	8C9. Ensures continuous improvement of individual, program, and organizational performance (e.g., mentoring, monitoring progress, adjusting programs to achieve better results)
	8B10. Advocates for the role of public health in providing population health services	8C10. Advocates for the role of public health in providing population health services

Tier Definitions

Tier 1 – Front Line Staff/Entry Level

Tier 1 competencies apply to public health professionals who carry out the day-to-day tasks of public health organizations and are not in management positions. Responsibilities of these professionals may include data collection and analysis, fieldwork, program planning, outreach, communications, customer service, and program support.

Tier 2 – Program Management/Supervisory Level

Tier 2 competencies apply to public health professionals in program management or supervisory roles. Responsibilities of these professionals may include developing, implementing, and evaluating programs; supervising staff; establishing and maintaining community partnerships; managing timelines and work plans; making policy recommendations; and providing technical expertise.

Tier 3 – Senior Management/Executive Level

Tier 3 competencies apply to public health professionals at a senior management level and to leaders of public health organizations. These professionals typically have staff who report to them and may be responsible for overseeing major programs or operations of the organization, setting a strategy and vision for the organization, creating a culture of quality within the organization, and working with the community to improve health.

For more information about the Core Competencies, please contact Kathleen Amos at kamos@phf.org or 202.218.4418.

The Council on Linkages Between Academia and Public Health Practice

Use of the Core Competencies for Public Health Professionals in Academia: Results of Healthy People 2020 Data Collection

August 15, 2016

Overview

Within *Healthy People 2020*, the Core Competencies for Public Health Professionals (Core Competencies) are incorporated into three objectives in the Public Health Infrastructure (PHI) topic area. The Council on Linkages Between Academia and Public Health Practice (Council on Linkages) serves as the data source for the third of these objectives, PHI-3: *Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula*. In early 2016, mid-point review data related to this objective were collected. With the assistance of three Council on Linkages member organizations, the Association of Schools and Programs of Public Health (ASPPH), the Association for Prevention Teaching and Research, and the American Association of Colleges of Nursing, 213 institutions that met the criteria of the objective were asked to provide data on their use of the Core Competencies through an online form. Responses were received from 103 institutions, resulting in a 48% response rate, with 92% of these institutions stating that they have used the Core Competencies.

Summary of Responses to Questions About How Academic Institutions are Using the Core Competencies

Question 1: Has your academic institution used the Core Competencies for any of its public health or community health degree programs in any of the following ways? (Percentage of respondents who answered "Yes")

	Assessed gaps in curricula	Developed curricula	Assessed gaps in specific courses	Developed courses	Evaluated/assessed student skills and competencies for student or program planning purposes	Developed objectives for field practica or capstone projects	Based public health degree program competencies on the Core Competencies	Trained faculty	Other
CEPH-Accredited Schools of Public Health	76%	68%	64%	52%	76%	80%	76%	20%	16%
CEPH-Accredited Academic Programs	81%	77%	71%	69%	77%	63%	79%	27%	13%
Schools of Nursing	80%	88%	75%	79%	76%	88%	80%	37%	0%
Total	**79%**	**77%**	**70%**	**67%**	**76%**	**74%**	**78%**	**27%**	**11%**

Other ways in which institutions used the Core Competencies:

CEPH-Accredited Schools of Public Health

- In preparation for re-accreditation in 2012, as advised by CEPH, we reviewed the Core Competencies from the Council on Linkages, the ASPPH competencies, and competencies from other institutions to develop 10 core Master of Public Health (MPH) competencies and 5-7 concentration-specific competencies for each of the five public health disciplines in our college. Our PhD competencies were revised as well. Following CEPH's advice to select and adapt (and not use all) the Council on Linkages' Core Competencies, our public health competencies reflect, but do not include the entire list of Core Competencies by the Council on Linkages. The responses to this survey pertain to our college competencies, which were based on the Core Competencies from the Council on Linkages.
- As part of our self-study for CEPH.
- We use the professional competencies for our continuing education programs, e.g., our public health training center programs for health department employees and other public health workers. We also indirectly integrate and assess some of the same skills contained in the professional competency sets in courses and practicum projects, although we primarily use the academic public health competencies for this purpose.

- The correct answer to this question would be sometimes depending upon the department and/or the faculty.
- The school used ASPPH's Core Competencies Model related directly with the Core Competencies referenced in this survey.

CEPH-Accredited Academic Programs

- We initially chose competencies for our MPH program from among the Council on Linkages' Core Competencies, but were told there were too many, and so we needed to develop fewer, broader ones.
- Vetting sites for experiential learning.
- Reviewed these competencies as we were developing our own set of program competencies.
- Trained public health professionals in the community.

Schools of Nursing

- We have been using the Bachelor of Science in Nursing essentials for all of our competency assessments.

Question 2: Has your academic institution integrated competencies into its curriculum using the Core Competencies for any of its public health or community health degree programs in any of the following ways? (Percentage of respondents who answered "Yes")

	Added specific content intended to build skills and/or competencies	Designed field placements/internships to build skills and/or competencies	Designed exercises or assignments to build skills and/or competencies	Brought in external speakers/faculty to help teach or address the Core Competencies	Tested students for attainment of skills and competencies during or after completion of a course	Other
CEPH-Accredited Schools of Public Health	72%	72%	68%	60%	64%	20%
CEPH-Accredited Academic Programs	81%	63%	73%	35%	65%	8%
Schools of Nursing	92%	84%	84%	38%	50%	25%
Total	**81%**	**71%**	**75%**	**41%**	**61%**	**12%**

Other ways in which institutions integrated the Core Competencies:

CEPH-Accredited Schools of Public Health

- The faculty have developed competencies in their departments. They use these competencies for their curricula and courses. These competencies are not always linked to the Core Competencies.
- Surveyed students and employers asking if they felt competencies were addressed and met via the degree curricula.
- Brought speakers to meetings of an organization of public health students in the college to speak on different topics related to college public health competencies. Organized workshops for continuing education which addressed, developed, or reinforced public health competencies. Sponsored a 2016 regional public health association conference, which brought together public health professionals, students, and faculty, with presentations by invited speakers and public health trainees, recipients of a Health Resources and Services Administration grant.

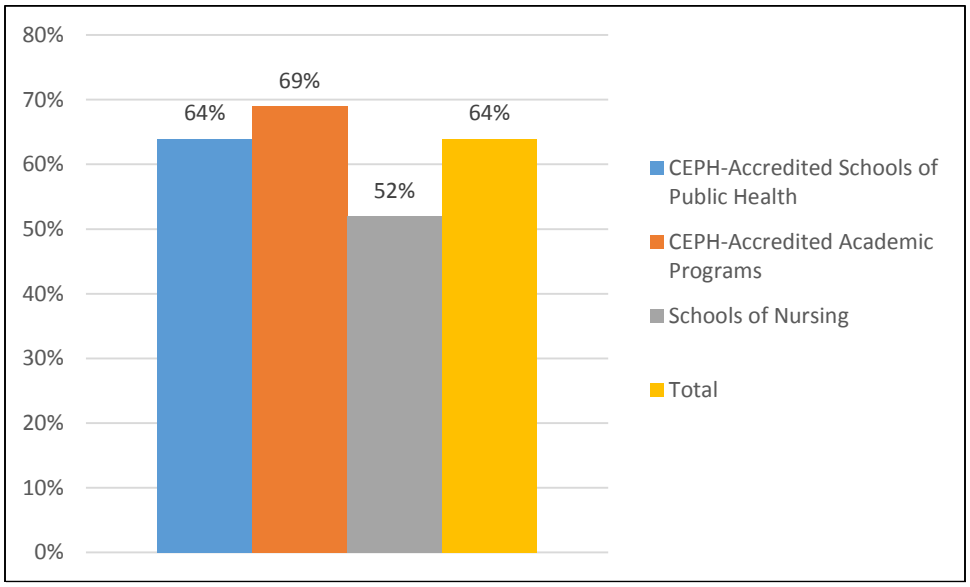
CEPH-Accredited Academic Programs

- We survey students prior to taking their first class and after completing Capstone to measure their self-perceived level of competence in selected areas. Then, through our course work, each course links assignments to learning objectives and core competencies identified for our program.

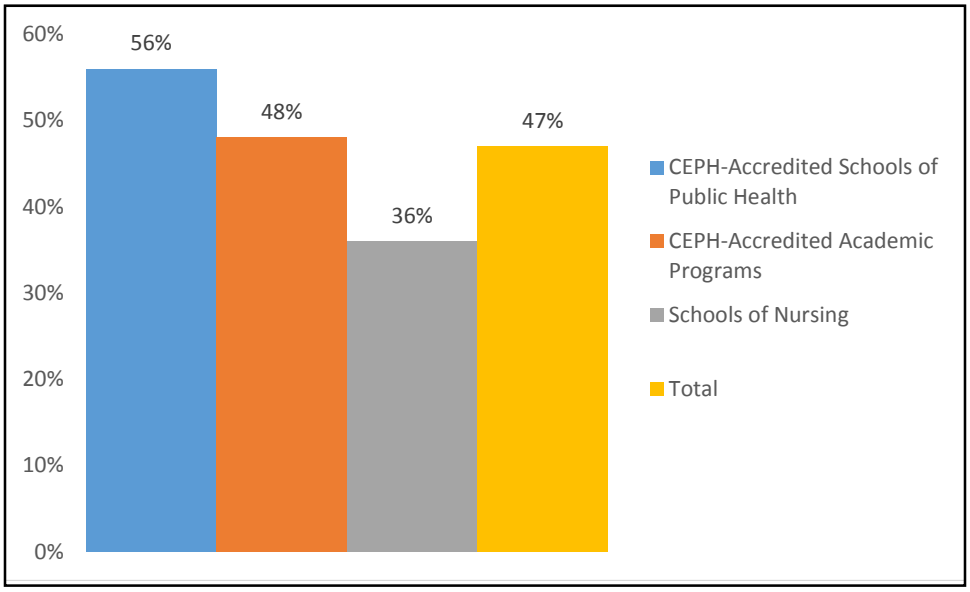
Schools of Nursing

- Our comprehensive examination, in lieu of thesis, done outside of coursework/classroom setting, is our examination of students' understanding and application of basic principles, including these competencies.
- Our new Master of Science in Nursing Association of Public Health Nurses curriculum based on the Quad Council Competencies for Public Health Nursing has not been offered yet. The curriculum has been approved and we are currently registering students.

Question 3: Before your academic institution grants a degree in any of its public health or community health degree programs, is there an assessment or evaluation of Core Competencies attained by a student? (Percentage of respondents who answered "Yes")



Question 4: Does your academic institution provide training for the current public health workforce using the Core Competencies? (Percentage of respondents who answered "Yes")



The Council on Linkages Between Academia and Public Health Practice

Recruitment and Retention: What's Influencing the Decisions of Public Health Workers?

Council on Linkages Between Academia and Public Health Practice

February 2016

This report is available online at: www.phf.org/PHworkersurvey. The data collected through this survey is available for further research by request. Questions or requests for data can be sent to PHWorkforce@phf.org.

Suggested Citation

Council on Linkages Between Academia and Public Health Practice. (2016). *Recruitment and Retention: What's Influencing the Decisions of Public Health Workers?* Washington, DC: Public Health Foundation.

Council on Linkages Between Academia and Public Health Practice

The Council on Linkages Between Academia and Public Health Practice (Council on Linkages; www.phf.org/councilonlinkages) is a collaborative of 21 national organizations focused on improving public health education and training, practice, and research. Established in 1992 to implement the recommendations of the Public Health Faculty/Agency Forum (www.phf.org/PHfacultyagencyforum), the Council on Linkages works to further academic/practice collaboration to ensure a well-trained, competent workforce and the development and use of a strong evidence base for public health practice.

Mission

The Council on Linkages strives to improve public health practice, education, and research by fostering, coordinating, and monitoring links among academia and the public health practice and healthcare communities; 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.

Membership

Twenty-one national organizations are represented on the Council on Linkages:

- American Association of Colleges of Nursing
- American College of Preventive Medicine
- American Public Health Association
- Association for Prevention Teaching and Research
- Association of Accredited Public Health Programs
- Association of Public Health Laboratories
- Association of Schools and Programs of Public Health
- Association of State and Territorial Health Officials
- Association of University Programs in Health Administration
- Centers for Disease Control and Prevention
- Community-Campus Partnerships for Health
- Council on Education for Public Health
- Health Resources and Services Administration
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- National Environmental Health Association
- National Library of Medicine
- National Network of Public Health Institutes
- National Public Health Leadership Development Network
- Quad Council Coalition of Public Health Nursing Organizations
- Society for Public Health Education

The Council on Linkages is funded by the Centers for Disease Control and Prevention. Staff support is provided by the Public Health Foundation.

Pipeline Workgroup

The Council on Linkages Between Academia and Public Health Practice's (Council on Linkages') Pipeline Workgroup (www.phf.org/pipelineworkgroup) aims to identify ways to strengthen the public health workforce by better understanding the ways public health workers enter the workforce, their rationale for entering the workforce, and factors that influence their decisions to remain working in public health.

Chair

- Vincent Francisco, Department of Applied Behavioral Science, The University of Kansas

Members

- Susan Allan, School of Public Health, University of Washington
- Magaly Angeloni, Rhode Island Department of Health
- Roxanne Beharie, Ashford University
- Ralph Cordell, Centers for Disease Control and Prevention (CDC)
- Pat Drehobl, CDC
- Clese Erikson, Health Workforce Research Center, The George Washington University
- Eric Gebbie, Public Health Division, Oregon Health Authority
- Julie Gleason-Comstock, School of Medicine, Wayne State University
- Georgia Heise, Three Rivers District Health Department (KY)
- Azania Heyward-James, CDC
- Jeff Jones, Jiann-Ping Hsu College of Public Health, Georgia Southern University
- Beth Lamanna, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
- Susan Lepre, Public Health Consultant
- Jean Moore, School of Public Health, State University of New York at Albany
- Robin Pendley, National Center for Health Statistics, CDC
- Beverly Smith, Health Resources and Services Administration
- Henry Taylor, Bloomberg School of Public Health, Johns Hopkins University
- Tanya Uden-Holman, College of Public Health, University of Iowa
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Key Findings

The public health workforce represents a critical element of the nation's health system, and ensuring a sufficient, capable workforce is key to ensuring the health of Americans. In conducting a survey of public health workers, the Council on Linkages Between Academia and Public Health Practice aimed to learn more about the individuals who participate in the public health workforce and their reasons for doing so to help build a foundation on which to base strategies for recruiting and retaining public health workers. The findings presented in this report suggest a number of potential considerations for public health policymakers, leaders, managers, and others involved in workforce initiatives. The following represent key findings from the nearly 12,000 public health workers who responded to this survey.

Recruitment and Retention

- **The factors that survey respondents valued in making employment decisions tended to be organizational more than personal,** and therefore, were factors that organizations have more ability to influence. These included the specific activities involved in a position, job security, competitive benefits, and identifying with the mission of the organization.
- **Linking workers to the vision and mission of public health may support recruitment and retention.** Several influential factors in respondents' decisions to begin and continue working for employers were intricately tied to individuals' feelings regarding the nature of public health work. The specific activities involved in a position, identifying with the mission of the organization, having a personal commitment to public service, and wanting a job in the public health field all received high ratings for their influence on employment decisions.
- **In planning recruitment and retention efforts, it may be more effective to focus on job security and benefits than on salary.** Among the most influential factors reported by respondents for both recruitment and retention were job security and competitive benefits, both of which received higher average ratings than competitive salaries.
- **Cuts to benefit packages may negatively impact recruitment and retention within public health.** Given the reported importance of competitive benefits in terms of respondents' employment decisions, future recruitment and retention efforts may be harmed if employers cut back on benefits.
- In general, **the factors that influence survey respondents' decisions to begin working for employers were the same factors that were important in their decisions to continue working for those employers.**
- **Healthcare settings, as well as private industry, may provide opportunities for recruiting workers into governmental public health.** For respondents entering governmental public health, approximately 31% came from healthcare services and 23% from private industry.
- **An additional opportunity for recruitment may be presented by academic programs**, as 33% of respondents indicated entering public health directly from educational programs, although not necessarily from public health programs. Only 10% of respondents reported coming into governmental public health from public health degree programs.
- Although survey respondents rated opportunities for training or continuing education as fairly important in their decisions to enter and remain working in public health positions, **attention to and resources for professional development appeared to be less than desirable**. With respect to professional development within their organizations,

respondents indicated being less than satisfied with the level of funds and resources available to allow them to take advantage of professional development opportunities.

- The number of survey respondents entering governmental public health directly from educational programs in areas other than public health and the relatively low levels of formal public health education reported by respondents, combined with the high levels of dissatisfaction related to aspects of professional development, suggest that **there may be opportunities to strengthen options for continuing education and training aimed at building public health skills within the workforce**.
- **By focusing on building leadership and management skills, public health organizations may be able to positively impact recruitment and retention through actions that do not require substantial additional funding.** The environment in which people work can significantly impact their satisfaction with and desire to remain in their jobs, and responses related to leadership and management within public health organizations indicated room for improvement.

Demographics

- In general, **respondents tended to be closer to the end of their careers than the beginning.** The average age of public health workers responding to this survey was 47. More than half (58%) were 45 or older, while only 15% were under the age of 35. In addition, approximately half of the respondents had been employed in public health for more than 10 years, with nearly one-quarter working in public health for more than 20 years.
- **There appeared to be limited diversity among the public health workers responding to this survey.** Significant majorities of respondents identified as female, White, and non-Hispanic.
- **Nurses accounted for one in four survey respondents.** Public health as a field encompasses a wide variety of specialties; however, 26% of respondents indicated that their primary professional role was as a nurse. With the exception of administrative and management positions, this percentage was more than double that of any other role reported on the survey.
- **Relatively few survey respondents completed their education with degrees specifically in public health.** While 55% of respondents held bachelor's, master's, or doctoral degrees at the start of their public health careers, only 9% of those indicated that their highest degree earned was in public health. This percentage had increased by the time of the survey, but still remained relatively low: 59% of workers had now earned bachelor's, master's, or doctoral degrees, with 11% reporting their highest degree was in public health.
- **The relative lack of public health degrees among survey respondents did not indicate a lack of education in general.** The most common level of education reported by respondents was a bachelor's degree. Both at entry into the field of public health and at the time of the survey, approximately one-third of respondents indicated that they had completed bachelor's degrees, while another 20% held more advanced degrees upon entering public health and 31% held these types of advanced degrees by the time of the survey.
- **Nearly one in five survey respondents continued their formal education after beginning work in the field.** In comparing education levels at the start of their public health careers and the time of the survey, 18% of respondents indicated continuing their education in some manner.
- **Nearly three out of four survey respondents indicated employment in governmental settings.** More respondents reported employment in various levels of

government (71%) than in any other setting; however, nearly one in four respondents (22%) indicated working in multiple settings and 24% worked exclusively outside of governmental settings. The most common non-governmental setting reported by respondents was healthcare services (26%).

Recruitment and Retention: What's Influencing the Decisions of Public Health Workers?

Introduction

The public health workforce is a vital part of the public health system. Protection of the public's health depends on maintaining a sufficient number of workers capable of delivering essential public health services. The recruitment of qualified and capable individuals into the field of public health and the retention of these individuals within the public health workforce are two important elements public health organizations must address to fulfill their responsibilities to the public. However, organizations often have limited time and resources for pursuing recruitment and retention efforts. In order to maximize the potential for success, ideally, recruitment and retention activities would be informed by evidence about influences on public health workers' employment decisions.

For more than 20 years, the Council on Linkages Between Academia and Public Health Practice[1] (Council on Linkages) has been leading workforce development efforts within the field of public health. In response to growing concern about emerging worker shortages within public health, in 2007, the Council on Linkages established the Pipeline Workgroup[2] to identify ways to strengthen the public health workforce by better understanding the ways public health workers enter the workforce, their rationale for entering the workforce, and factors that influence their decisions to remain working in public health. The Pipeline Workgroup's mandate included reviewing literature related to the public health workforce[3-5], considering existing workforce data and data sources, and convening experts from a variety of fields to share experiences addressing worker shortages. Based on the Workgroup's exploration, in 2008, the Council on Linkages concluded that the data available on the public health workforce were insufficient for developing evidence-supported recruitment and retention strategies.

To help address this gap, the Council on Linkages conducted a national survey in 2010 to learn more about public health workers and the factors that influence their employment decisions. This effort aimed to survey public health workers in the United States directly, and the findings offer insights for public health policymakers, leaders, managers, and others involved in workforce recruitment and retention.

Study Purpose

The Council on Linkages developed and conducted a survey of public health workers to gather information about individual workers who make up the US public health workforce. This survey focused on recruitment and retention within public health, exploring how and why workers enter and remain in the field and their satisfaction with the organizational environments in which they work. Specifically, the survey collected demographic information about individual public health workers; data on factors that initially attracted workers to public health and those that impacted their decisions to remain working in the field; and perspectives on a variety of factors related to organizational leadership, management, and professional development.

Study Methodology

The Council on Linkages' survey of public health workers was developed and distributed in 2009-2010. This online survey was designed to capture information about the characteristics of public health workers, factors influencing their employment decisions, and their satisfaction with work environments. The survey was distributed by email to over 70,000 public health workers in the spring and early summer of 2010, and responses were received from 11,640 individuals. These data were analyzed to begin providing insights for strengthening recruitment and retention efforts impacting the public health workforce.

Survey Design

The Council on Linkages' survey was developed by its Pipeline Workgroup in consultation with researchers at the University of Kentucky College of Public Health and drew on previous work in the area of recruitment and retention. Surveys from other disciplines, including education and nursing, were reviewed, and questions were adapted or developed to be specific to public health. Pilot tests of the survey were conducted with approximately 20 volunteers from the public health workforce and focus groups were held, with the information obtained used to further refine survey questions.

The final survey contained 28 questions addressing the demographics of public health workers, recruitment into public health, retention within public health, and organizational environment (see the Appendix). Twenty-seven of the questions were closed-ended, while one question was open-ended. All questions were optional, and the number of questions presented to individual respondents varied based on the answers provided. The Council on Linkages was particularly concerned about recruitment and retention of workers in governmental public health agencies, and as a result, the survey included several questions specifically for governmental public health workers.

This study was approved by the University of Kentucky's Institutional Review Board, and the opportunity to enter a drawing for small prizes was offered as an incentive for participation in the survey.

Survey Audience and Distribution

The survey targeted public health workers in the US, with a particular interest in those working in governmental public health settings. Potential survey respondents were identified using the TRAIN learning management network[6] developed and operated by the Public Health Foundation. TRAIN is an account-based online training system designed to support public health and represents the largest repository of individual-level information on the US public health workforce[7-8]. At the time of the survey, TRAIN had approximately 320,000 active registered users from across the US and beyond, and 24 affiliate states and national organizations used the system to provide their workers with access to public health training.

Each of the 24 TRAIN affiliates was invited to participate in the survey. Twenty-one of the affiliates agreed, allowing all public health workers in their states or organizations who were registered on TRAIN to be contacted for the survey. Public health workers from one non-affiliate state, Alabama, were also invited to participate.

This survey was distributed by email in the spring of 2010 to 70,315 individuals. Distribution occurred over a five-week period using a four-step process that included an email announcing the upcoming survey, an email inviting participation in the survey, and two reminder emails.

Data Analysis

Data gathered were analyzed using descriptive statistics, including tabulations and mean value calculations. Demographic characteristics of respondents were summarized. Additionally, responses to questions about factors that influenced respondents' decisions to begin and continue working for their current employers, as well as about perceptions of organizational environment, were tabulated to provide insights for workforce recruitment and retention efforts within public health.

Response Rates

The survey was distributed to 70,315 public health professionals, and 11,640 responses were received, for a response rate of approximately 17%. As all survey questions were optional, response rates for individual questions varied, ranging from a high of 99.9% of respondents ("Have you ever been employed by a governmental public health agency?") to a low of 25% ("Is there anything else you would like to tell us that we did not ask?").

Limitations

This survey was the first national effort to collect data on recruitment and retention factors directly from individual public health workers within the US, and the responses obtained from more than 11,000 individuals represent a valuable dataset for exploring these factors. These data represent a significant contribution to public health workforce research and can help inform decisions regarding recruitment and retention strategies; however, in interpreting the results of this survey, several limitations should be taken into consideration.

As is typical with surveys, the data are self-reported by the individuals who chose to respond to the survey. Although survey responses were received from public health workers across all 50 states and Washington, DC, the majority of respondents represent the states formally invited to participate in the survey. Potential survey respondents were identified almost exclusively from public health workers with active accounts in TRAIN at the time of the survey, and the survey had a response rate of 17%. Findings represent the survey respondents at the point in time that the survey was conducted and may not be generalizable to the entire public health workforce. Additionally, the survey focused on current public health workers, and the data do not reflect individuals who formerly worked in public health, but had left that workforce. The data collected cannot shed light on why people chose to pursue employment options outside of public health, only on why people chose to join and stay in the field.

Report Structure

This report describes findings from the survey of public health workers conducted by the Council on Linkages in 2010. The findings shared in this report are organized into three sections, which mirror the focus areas found in the survey:

- Demographics
- Recruitment and Retention
- Organizational Environment

Implications and conclusions based on these findings are also discussed.

Throughout the report, the findings represent the responses of the 11,640 individuals who participated in the Council on Linkages' survey. As all survey questions were optional, the number of individuals who responded to each question varied. In addition, some questions were only presented to select groups of respondents based on their answers to previous questions.

Demographics

Learning more about the individuals who comprise the public health workforce is an important aspect of effective recruitment and retention efforts. This section describes the demographics of survey respondents.

Work Location

Responses to this survey were received from individuals in all 50 states, the District of Columbia, and several US territories. The survey primarily targeted public health workers in states participating in TRAIN, as well as Alabama, and the majority of survey respondents reported working in one of those states. Responses from non-targeted states and territories may represent workers who were affiliated with the Centers for Disease Control and Prevention's Division of Global Migration & Quarantine or the Medical Reserve Corps, two non-state-based TRAIN affiliates, or workers who were registered users of National TRAIN and may have been located anywhere in the US. The number of responses received from workers in individual states and territories ranged from a high of 1,398 for Texas to a low of 1 each for American Samoa and the Northern Mariana Islands. Workers in seven states – Texas, Virginia, Kentucky, Wisconsin, Arkansas, Ohio, and Oklahoma – accounted for 57% of the survey responses (n=6,585), and 11% of respondents (n=1,320) did not provide their state or territory of employment.

Table 1. Work Locations of Survey Respondents (n=11,640)

State/Territory	Number of Survey Respondents	Percent of Survey Respondents
Alabama*	335	2.9%
Alaska	11	0.1%
American Samoa	1	<0.1%
Arizona	21	0.2%
Arkansas*	690	5.9%
California*	205	1.8%
Colorado	44	0.4%
Connecticut*	388	3.3%
Delaware*	109	0.9%
District of Columbia	35	0.3%
Florida	141	1.2%
Georgia	58	0.5%
Guam	2	<0.1%
Hawaii*	38	0.3%
Idaho	9	0.1%
Illinois	63	0.5%
Indiana	37	0.3%
Iowa	17	0.1%
Kansas*	462	4.0%
Kentucky*	1,045	9.0%
Louisiana	19	0.2%
Maine	13	0.1%
Maryland	50	0.4%
Massachusetts	51	0.4%
Michigan*	337	2.9%
Minnesota	100	0.9%
Mississippi	14	0.1%

Missouri	57	0.5%
Montana	8	0.1%
Nebraska	11	0.1%
Nevada	12	0.1%
New Hampshire*	80	0.7%
New Jersey	66	0.6%
New Mexico	27	0.2%
New York	110	0.9%
North Carolina	83	0.7%
North Dakota	4	<0.1%
Northern Mariana Islands	1	<0.1%
Ohio*	579	5.0%
Oklahoma*	536	4.6%
Oregon	36	0.3%
Pennsylvania	56	0.5%
Puerto Rico	3	<0.1%
Rhode Island*	39	0.3%
South Carolina	26	0.2%
South Dakota	2	<0.1%
Tennessee*	98	0.8%
Texas*	1,398	12.0%
Trust Territory of the Pacific Islands	2	<0.1%
Utah*	131	1.1%
Vermont	6	0.1%
Virginia*	1,396	12.0%
Washington	54	0.5%
West Virginia*	157	1.3%
Wisconsin*	941	8.1%
Wyoming*	106	0.9%
No Response	1,320	11.3%

* State formally participated in the survey.

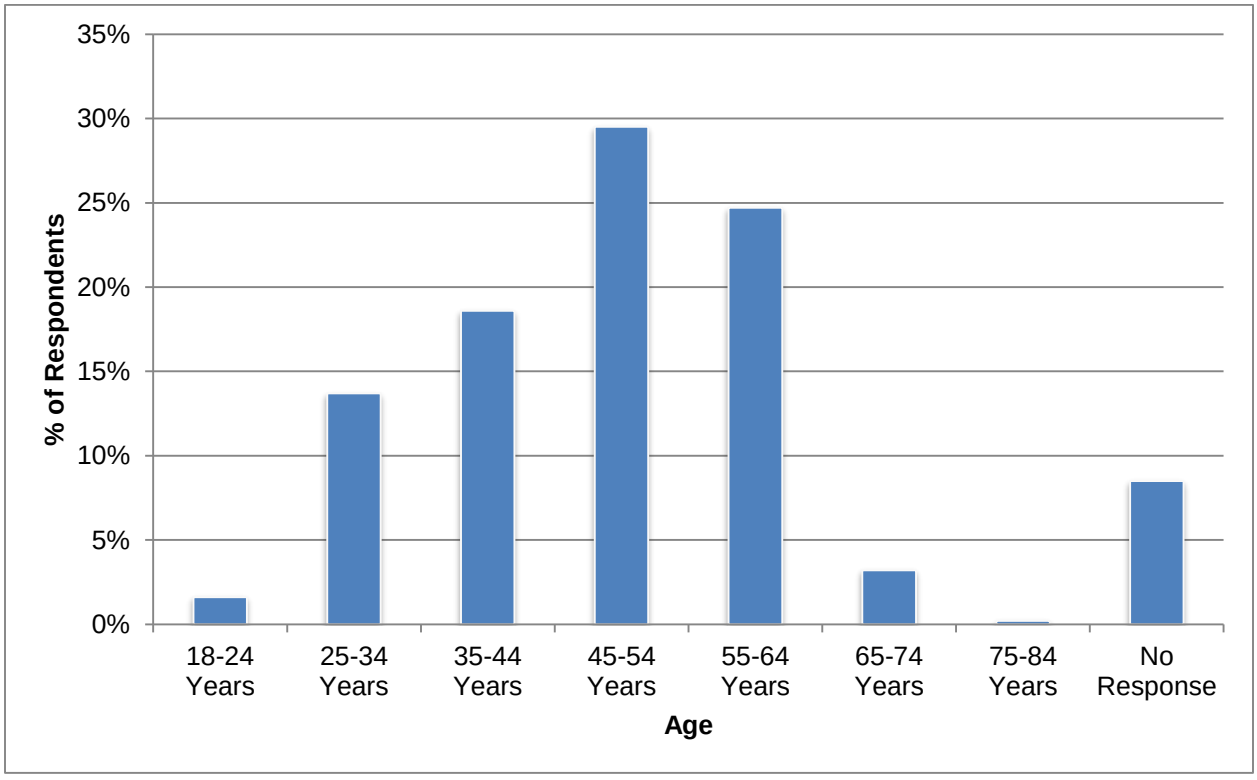
Age

Survey respondents ranged in age from 18 to 83 years, with a mean age of 47 years. Respondents aged 45-54 made up the largest single age group (30%; n=3,431). More than half (58%; n=6,696) were age 45 or older, with 28% (n=3,265) being 55 or older, while 34% (n=3,953) were younger than 45. Fifteen percent (n=1,784) were under age 35.

Table 2. Age of Survey Respondents (n=11,640)

Age	Number (Percent)
18-24 Years	184 (1.6%)
25-34 Years	1,600 (13.7%)
35-44 Years	2,169 (18.6%)
45-54 Years	3,431 (29.5%)
55-64 Years	2,870 (24.7%)
65-74 Years	376 (3.2%)
75-84 Years	19 (0.2%)
No Response	991 (8.5%)

Figure 1. Age of Survey Respondents (n=11,640)



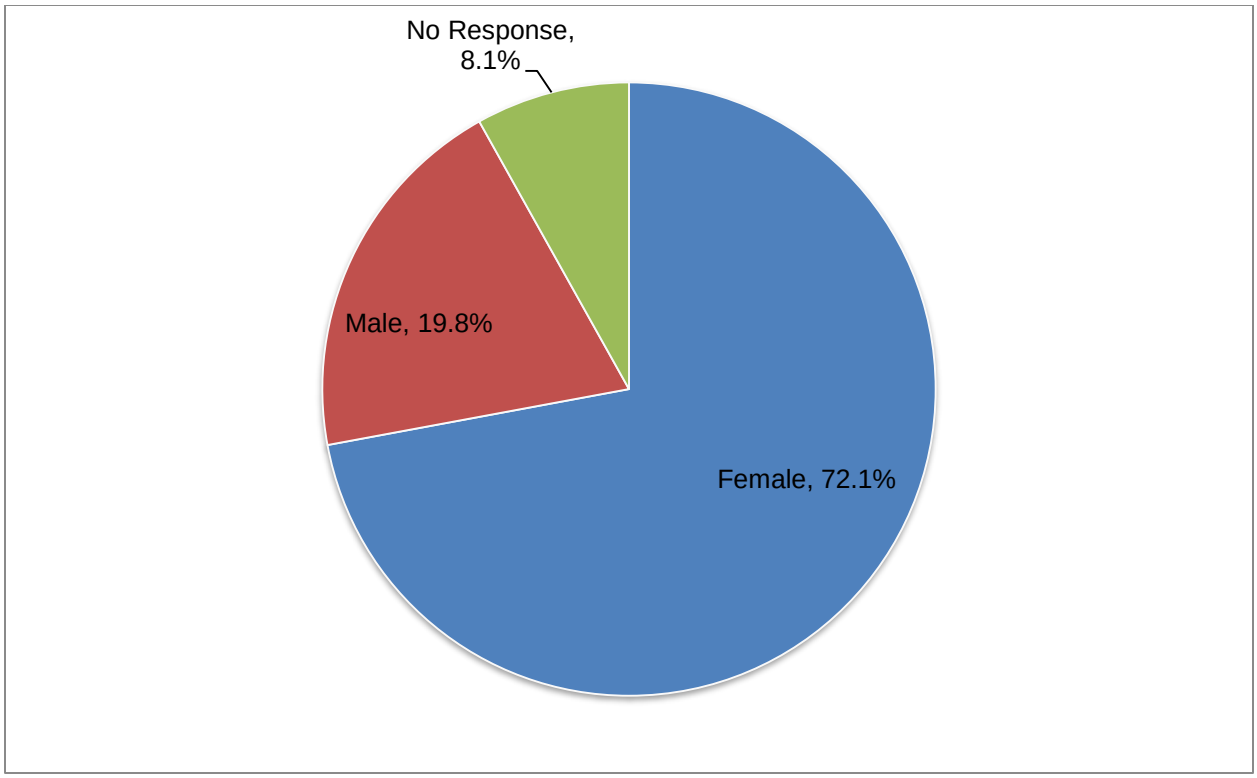
Gender

Survey respondents were predominantly female (72%; n=8,390); 20% of respondents (n=2,305) were male.

Table 3. Gender of Survey Respondents (n=11,640)

Gender	Number (Percent)
Female	8,390 (72.1%)
Male	2,305 (19.8%)
No Response	945 (8.1%)

Figure 2. Gender of Survey Respondents (n=11,640)



Race and Ethnicity

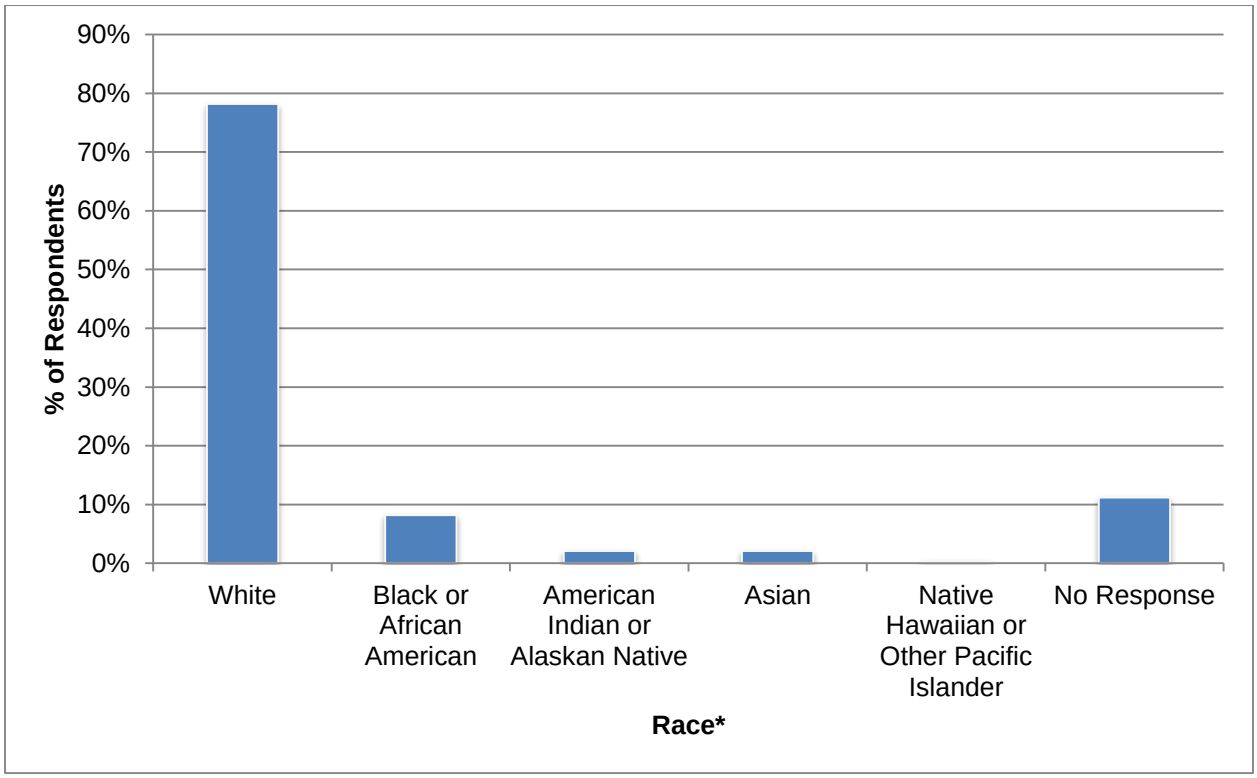
The majority of survey respondents were White (78%; n=9,097). Black or African American was the second most common race reported at 8% (n=951), and all other races combined accounted for less than 5% of responses (n=486). Two percent of respondents (n=216) selected multiple options, with the most common combination being White and American Indian or Alaska Native (n=138).

Table 4. Race of Survey Respondents (n=11,640)

Race*	Number (Percent)
White	9,097 (78.2%)
Black or African American	951 (8.2%)
American Indian or Alaska Native	249 (2.1%)
Asian	244 (2.1%)
Native Hawaiian or Other Pacific Islander	40 (0.3%)
No Response	1,300 (11.2%)

* Respondents could select multiple options.

Figure 3. Race of Survey Respondents (n=11,640)



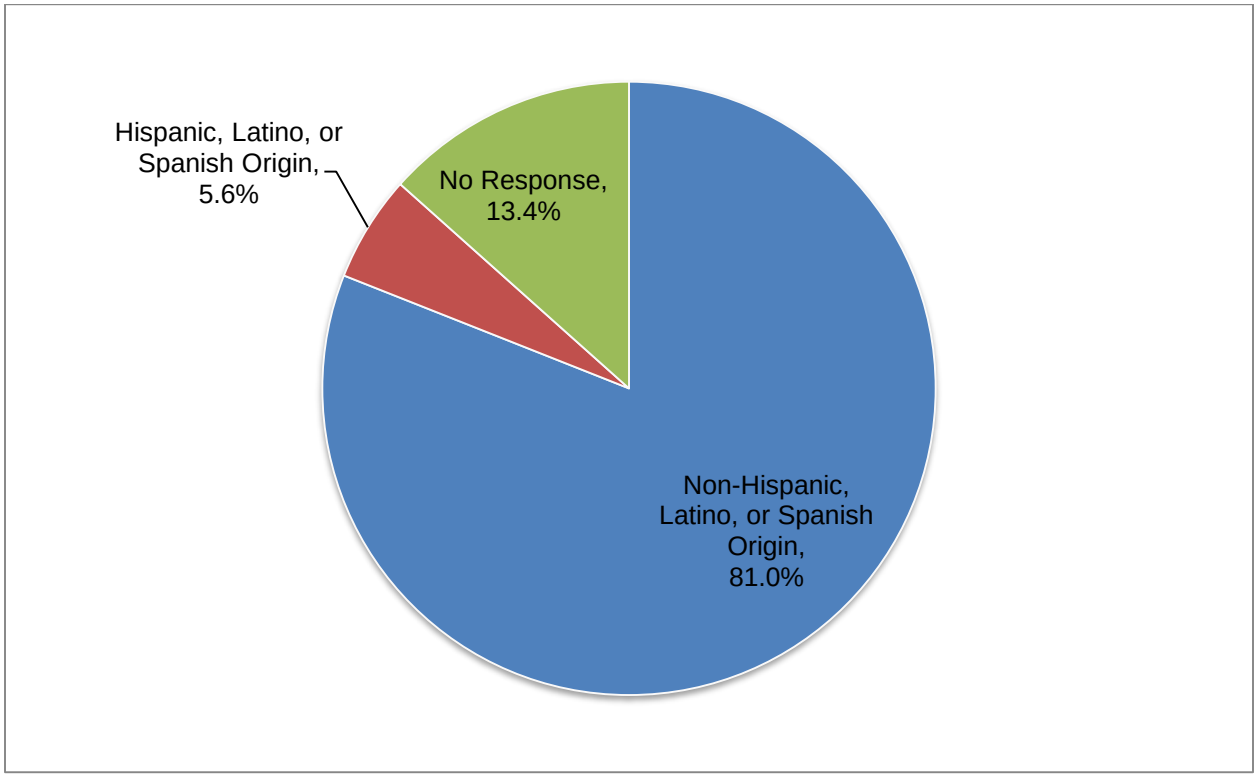
* Respondents could select multiple options.

With regard to ethnicity, approximately 6% of respondents (n=652) identified as Hispanic, Latino, or of Spanish origin.

Table 5. Ethnicity of Survey Respondents (n=11,640)

Ethnicity	Number (Percent)
Non-Hispanic, Latino, or Spanish Origin	9,424 (81.0%)
Hispanic, Latino, or Spanish Origin	652 (5.6%)
No Response	1,564 (13.4%)

Figure 4. Ethnicity of Survey Respondents (n=11,640)



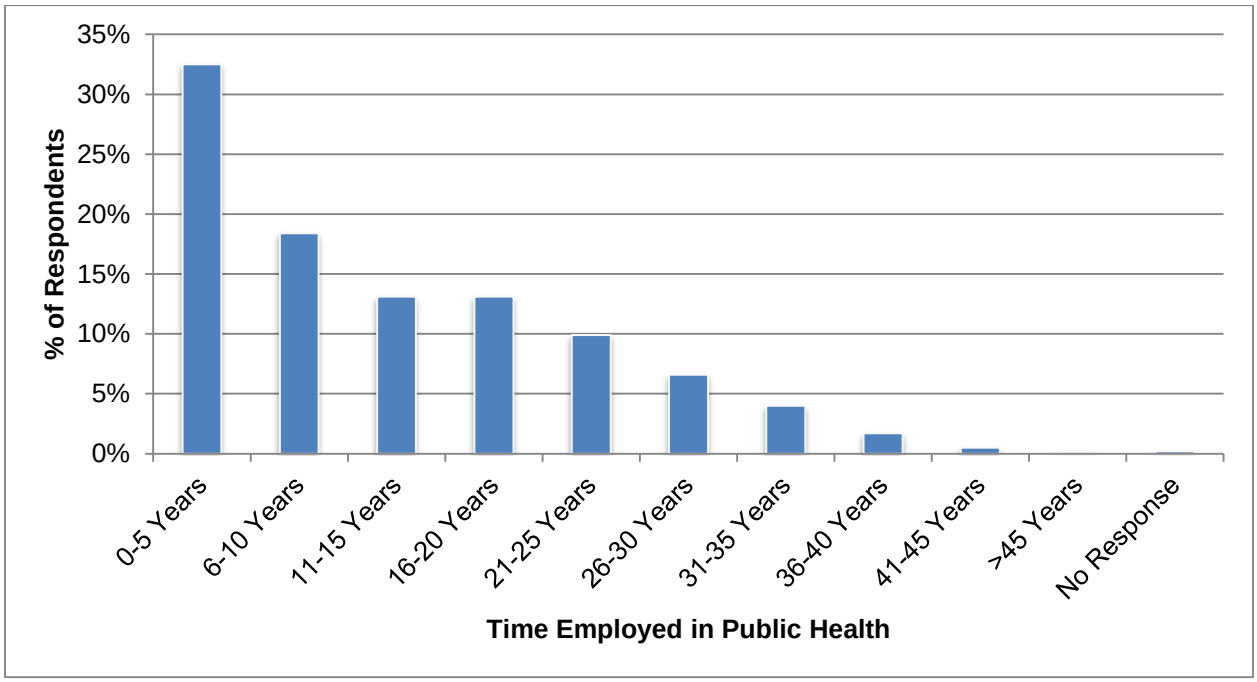
Length of Employment in Public Health

The average length of employment in public health among those who responded to the survey was nearly 13 years, with reported length of service ranging from 0 to 63 years. Nearly half of respondents (49%; n=5,694) had been employed in public health for more than 10 years, with 23% (n=2,652) employed for more than 20 years, while one-third had been employed for 5 years or less (33%; n=3,786).

Table 6. Length of Employment in Public Health of Survey Respondents (n=11,640)

Time Employed in Public Health	Number (Percent)
0-5 Years	3,786 (32.5%)
6-10 Years	2,136 (18.4%)
11-15 Years	1,522 (13.1%)
16-20 Years	1,520 (13.1%)
21-25 Years	1,157 (9.9%)
26-30 Years	773 (6.6%)
31-35 Years	461 (4.0%)
36-40 Years	194 (1.7%)
41-45 Years	53 (0.5%)
>45 Years	14 (0.1%)
No Response	24 (0.2%)

Figure 5. Length of Employment in Public Health of Survey Respondents (n=11,640)



Education

To explore the education level of public health workers, the extent to which workers continue their education after beginning public health careers, and the proportion of workers formally educated in public health, the educational background of survey respondents was considered at two points in time. Survey respondents reported the highest level of education they had completed when entering the field of public health, as well as their education level at the time of the survey, and whether their highest degree held was in public health.

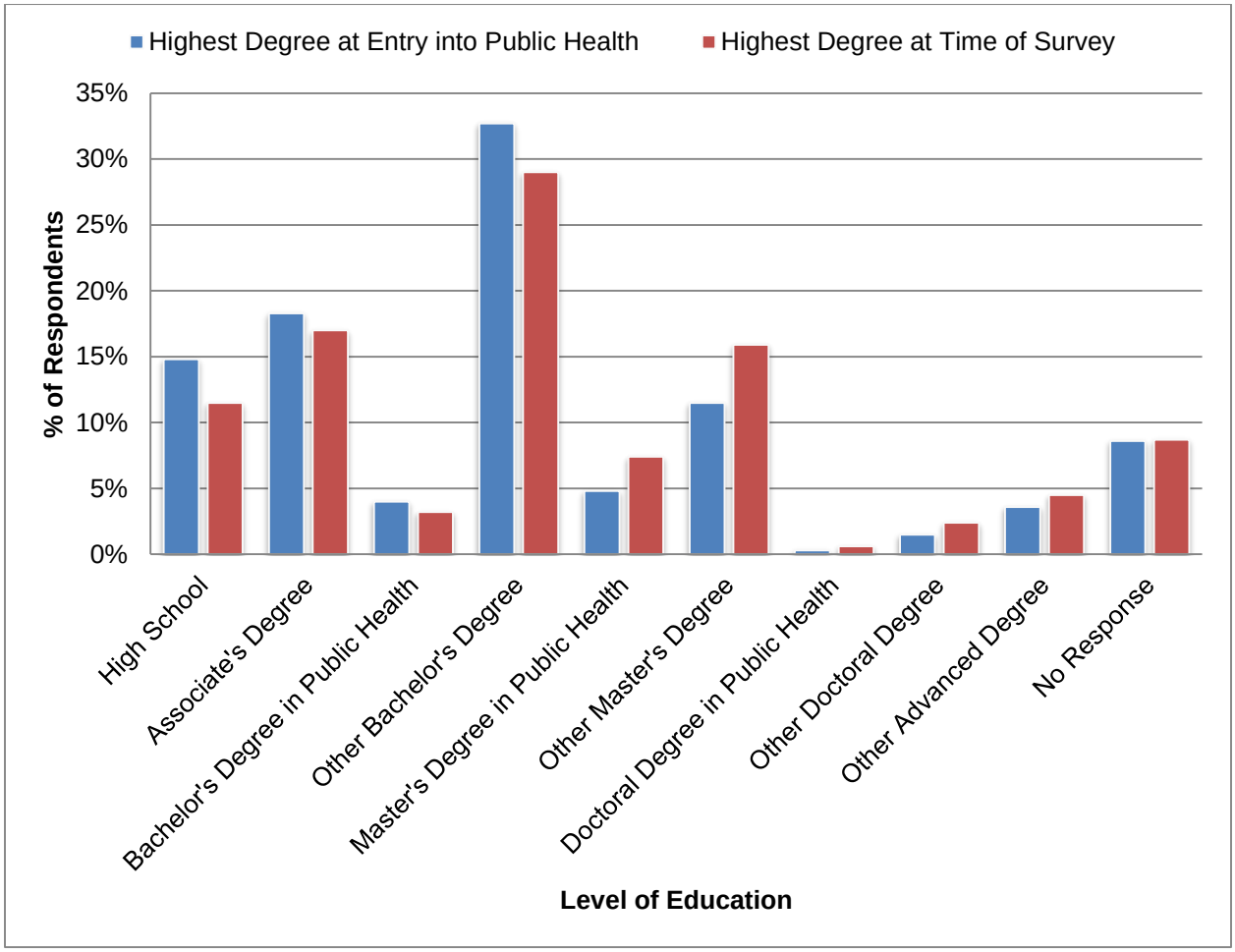
At the time of entry into the public health field, the most common highest degree held was a bachelor's degree, with 37% of respondents (n=4,271) reporting completing education at this level. An additional 33% of respondents (n=3,849) had completed less than a bachelor's degree, while 22% (n=2,516) held more advanced degrees. At the time of the survey, although a bachelor's degree remained the most common highest degree among respondents at 32% (n=3,740), the percentage of respondents holding more advanced degrees increased to 31% (n=3,580) and that holding less than a bachelor's degree decreased to 28% (n=3,309). Of the 10,629 respondents who reported their education level at both points in time, 18% (n=1,890) reported a change in education level, indicating that their education continued in some way after beginning their work in public health.

Survey respondents who reported that their highest degrees were in public health were in the minority. At entry into public health, 9% of respondents (n=1,056) had concluded their education with degrees in public health, with master's degrees most common at 5% of respondents (n=560). At the time of the survey, 11% of respondents (n=1,296) indicated that their highest level of education was a degree in public health. Master's degrees remained the most common type of public health degree at 7% (n=857).

Table 7. Education of Survey Respondents at Entry into Public Health and at Time of Survey (n=11,640)

Level of Education	Highest Degree at Entry into Public Health Number (Percent)	Highest Degree at Time of Survey Number (Percent)
High School	1,720 (14.8%)	1,335 (11.5%)
Associate's Degree	2,129 (18.3%)	1,974 (17.0%)
Bachelor's Degree in Public Health	466 (4.0%)	367 (3.2%)
Other Bachelor's Degree	3,805 (32.7%)	3,373 (29.0%)
Master's Degree in Public Health	560 (4.8%)	857 (7.4%)
Other Master's Degree	1,337 (11.5%)	1,855 (15.9%)
Doctoral Degree in Public Health	30 (0.3%)	72 (0.6%)
Other Doctoral Degree	172 (1.5%)	276 (2.4%)
Other Advanced Degree (e.g., MD, JD, etc.)	417 (3.6%)	520 (4.5%)
No Response	1,004 (8.6%)	1,011 (8.7%)

Figure 6. Education of Survey Respondents at Entry into Public Health and at Time of Survey (n=11,640)



Work Setting

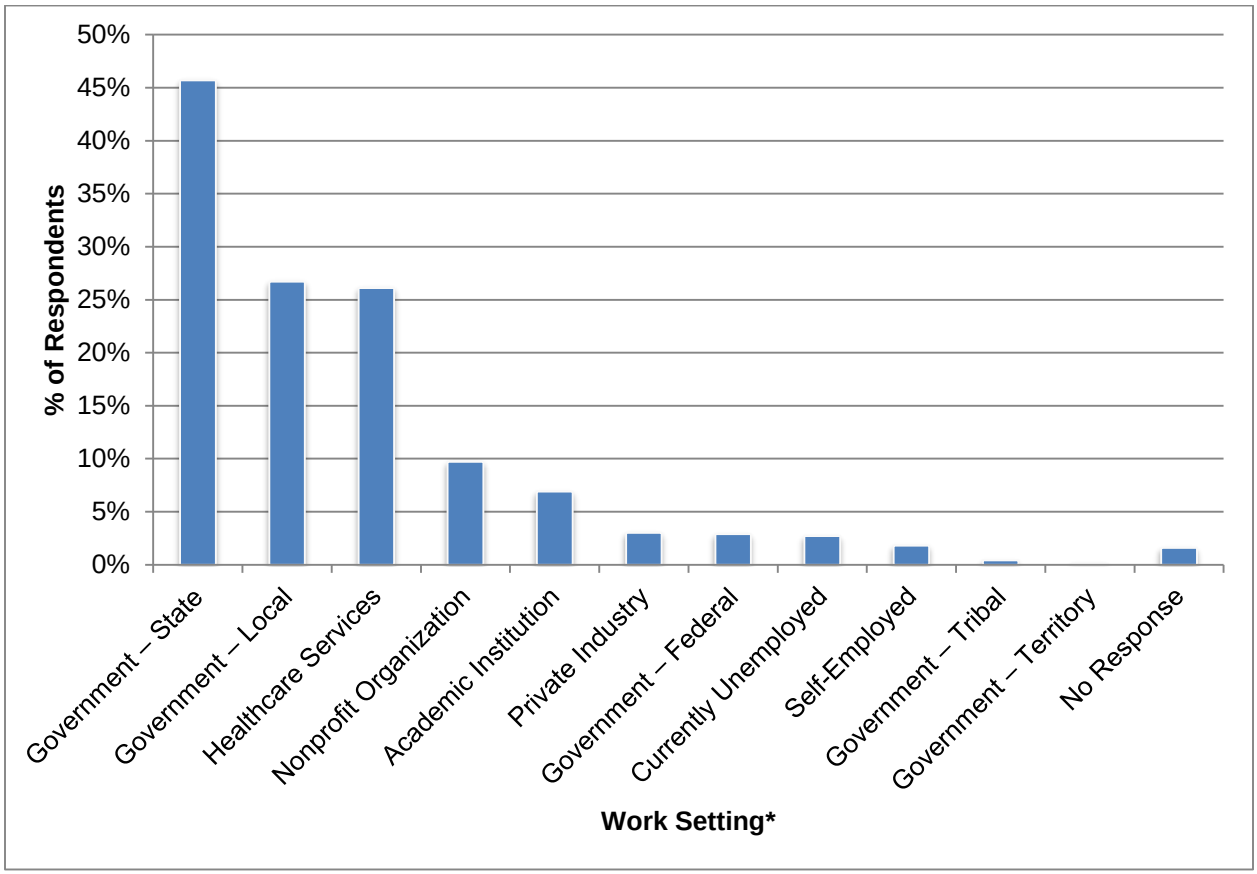
In terms of work setting, 71% (n=8,293) of respondents reported working within the government. Respondents were most likely to be employed in state government (46%; n=5,314), followed by local government (27%; n=3,105). Among non-governmental settings, 26% of respondents (n=3,035) worked in healthcare services and 10% (n=1,129) in nonprofit organizations. Few respondents worked in private industry (3%; n=347); were self-employed (2%; n=206); or were employed at the federal (3%; n=339), tribal (<1%; n=43), or territorial levels (<1%; n=16) of the government. Twenty-two percent of respondents (n=2,510) reported working in multiple settings, with the most common combination being state government and healthcare services (n=919), and 24% (n=2,841) worked exclusively outside of governmental settings.

Table 8. Current Work Setting of Survey Respondents (n=11,640)

Current Work Setting*	Number (Percent)
Government – State	5,314 (45.7%)
Government – Local	3,105 (26.7%)
Healthcare Services	3,035 (26.1%)
Nonprofit Organization	1,129 (9.7%)
Academic Institution	807 (6.9%)
Private Industry	347 (3.0%)
Government – Federal	339 (2.9%)
Currently Unemployed	319 (2.7%)
Self-Employed	206 (1.8%)
Government – Tribal	43 (0.4%)
Government – Territory	16 (0.1%)
No Response	182 (1.6%)

* Respondents could select multiple options.

Figure 7. Current Work Setting of Survey Respondents (n=11,640)



* Respondents could select multiple options.

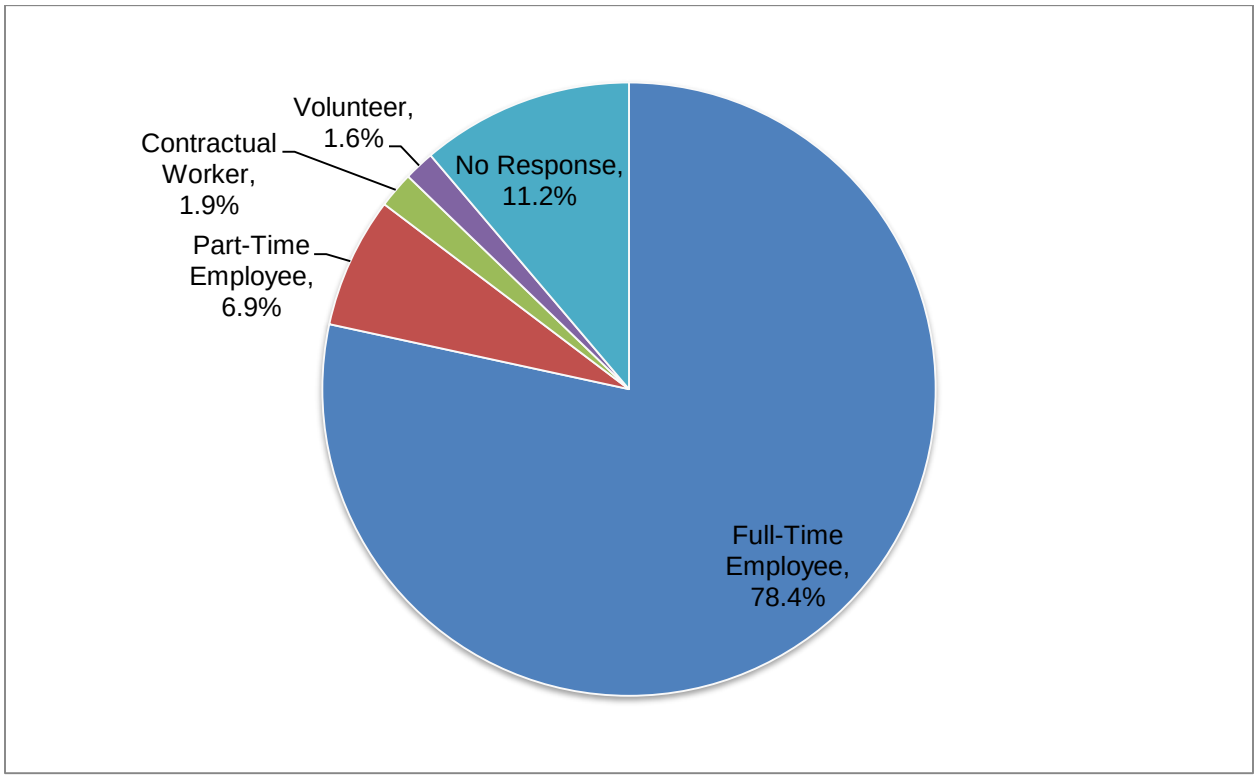
Employment Status

More survey respondents were employed full-time (78%; n=9,122) than were employed part-time (7%; n=804). Few respondents were employed on a contractual basis or served as volunteers (2% each).

Table 9. Employment Status of Survey Respondents (n=11,640)

Employment Status	Number (Percent)
Full-Time Employee	9,122 (78.4%)
Part-Time Employee	804 (6.9%)
Contractual Worker	222 (1.9%)
Volunteer	191 (1.6%)
No Response	1,301 (11.2%)

Figure 8. Employment Status of Survey Respondents (n=11,640)



Professional Role

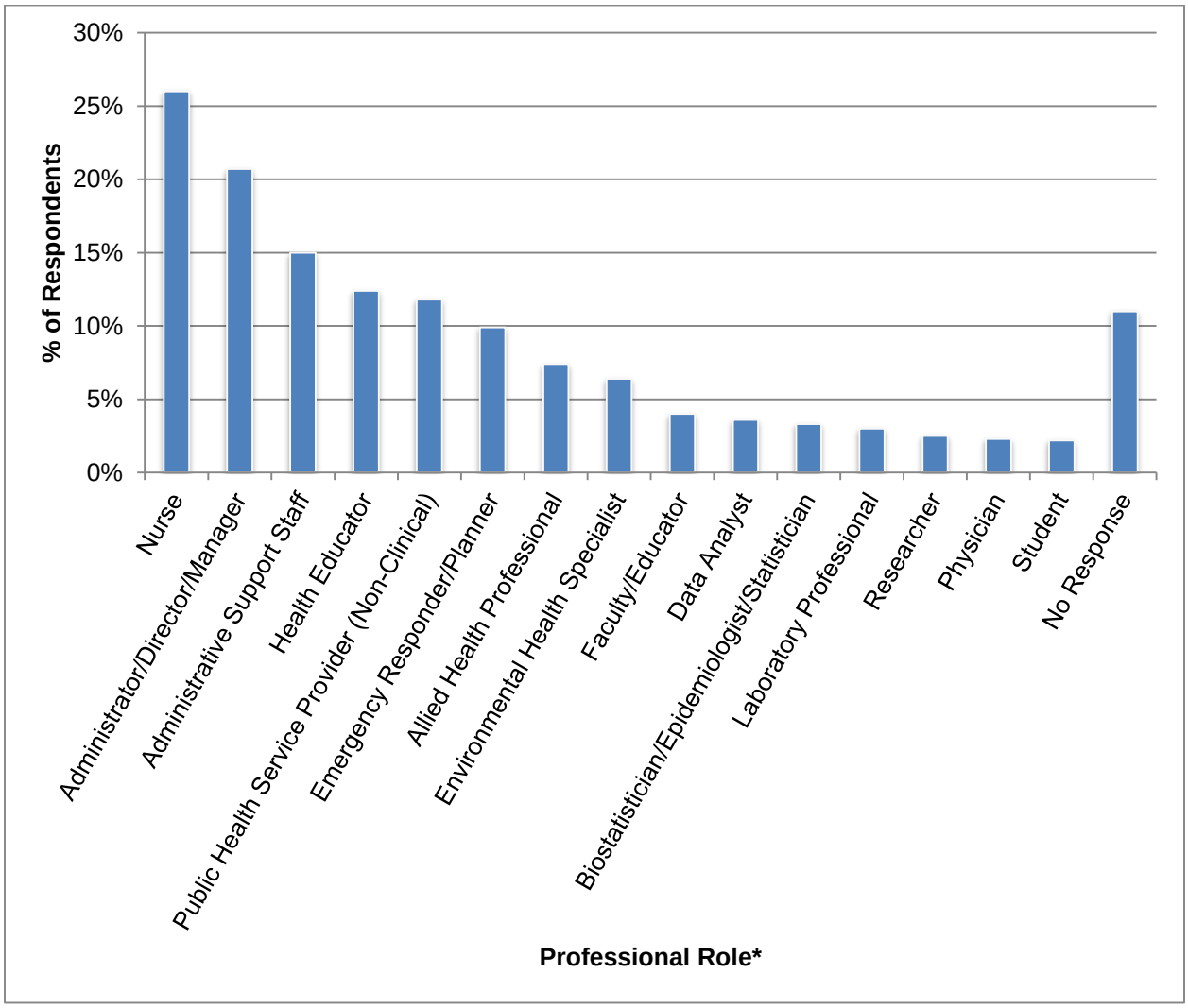
Nursing was the most common professional role among survey respondents; approximately one in four respondents (26%; n=3,022) reported working as a nurse. This was followed by administrative positions, with approximately one in five (21%; n=2,404) serving as an administrator, director, or manager and 15% (n=1,746) serving as administrative support staff. A variety of other professional roles were represented in lesser numbers among respondents, with the positions of researcher and physician among the least frequent (3% and 2%, respectively). Twenty-nine percent (n=3,398) of respondents reported filling multiple professional roles, with the most common combination being that of nurse and administrator/director/manager (n=503).

Table 10. Primary Professional Roles of Survey Respondents (n=11,640)

Primary Professional Role*	Number (Percent)
Nurse	3,022 (26.0%)
Administrator/Director/Manager	2,404 (20.7%)
Administrative Support Staff	1,746 (15.0%)
Health Educator	1,444 (12.4%)
Public Health Service Provider (Non-Clinical)	1,371 (11.8%)
Emergency Responder/Planner	1,152 (9.9%)
Allied Health Professional	859 (7.4%)
Environmental Health Specialist	742 (6.4%)
Faculty/Educator	467 (4.0%)
Data Analyst	418 (3.6%)
Biostatistician/Epidemiologist/Statistician	389 (3.3%)
Laboratory Professional	353 (3.0%)
Researcher	286 (2.5%)
Physician	262 (2.3%)
Student	261 (2.2%)
No Response	1,281 (11.0%)

* Respondents could select up to three options.

Figure 9. Primary Professional Roles of Survey Respondents (n=11,640)



* Respondents could select up to three options.

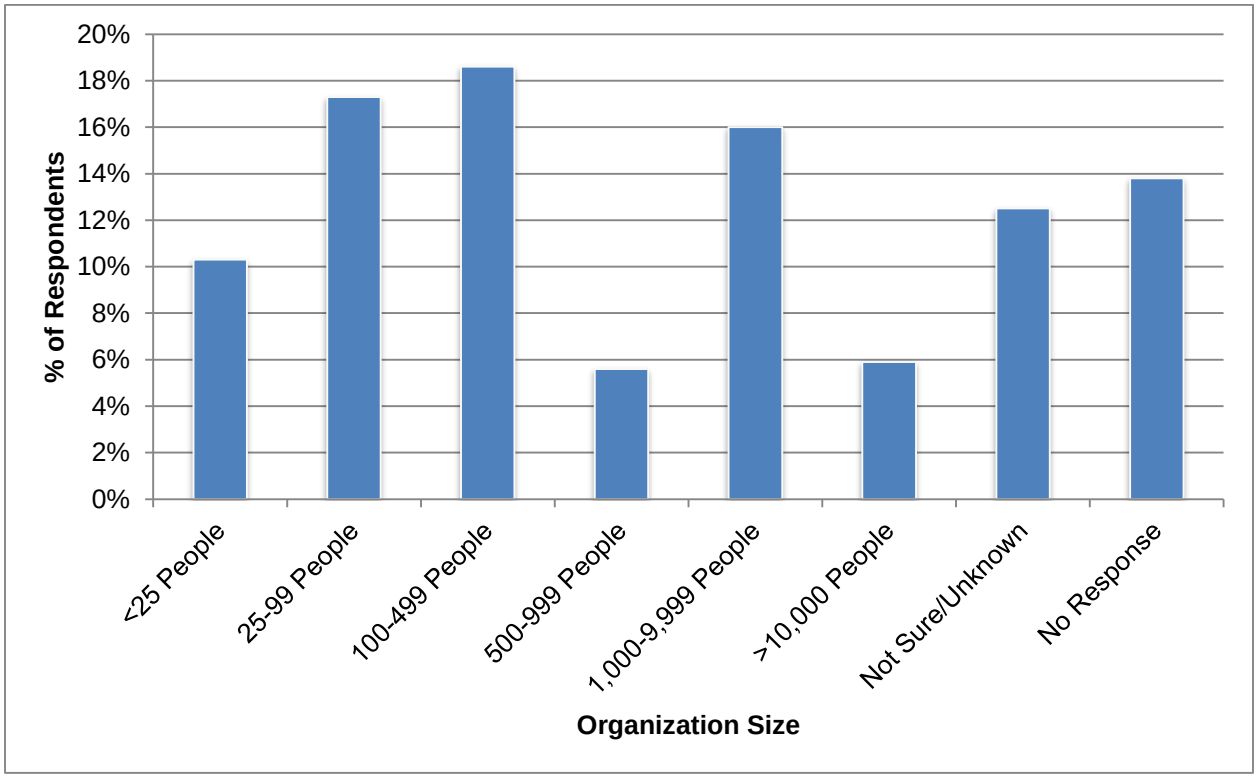
Organization Size

The organizations in which respondents were employed varied in size from fewer than 25 people to more than 10,000. Organizations employing 100-499 people were most common at 19% (n=2,166), although significant proportions of respondents were employed at organizations staffed by 25-99 people (17%; n=2,015) and 1,000-9,999 people (16%; n=1,866) as well.

Table 11. Size of Organizations Where Survey Respondents Work (n=11,640)

Size of Organization	Number (Percent)
<25 People	1,202 (10.3%)
25-99 People	2,015 (17.3%)
100-499 People	2,166 (18.6%)
500-999 People	647 (5.6%)
1,000-9,999 People	1,866 (16.0%)
>10,000 People	686 (5.9%)
Not Sure/Unknown	1,457 (12.5%)
No Response	1,601 (13.8%)

Figure 10. Size of Organizations Where Survey Respondents Work (n=11,640)



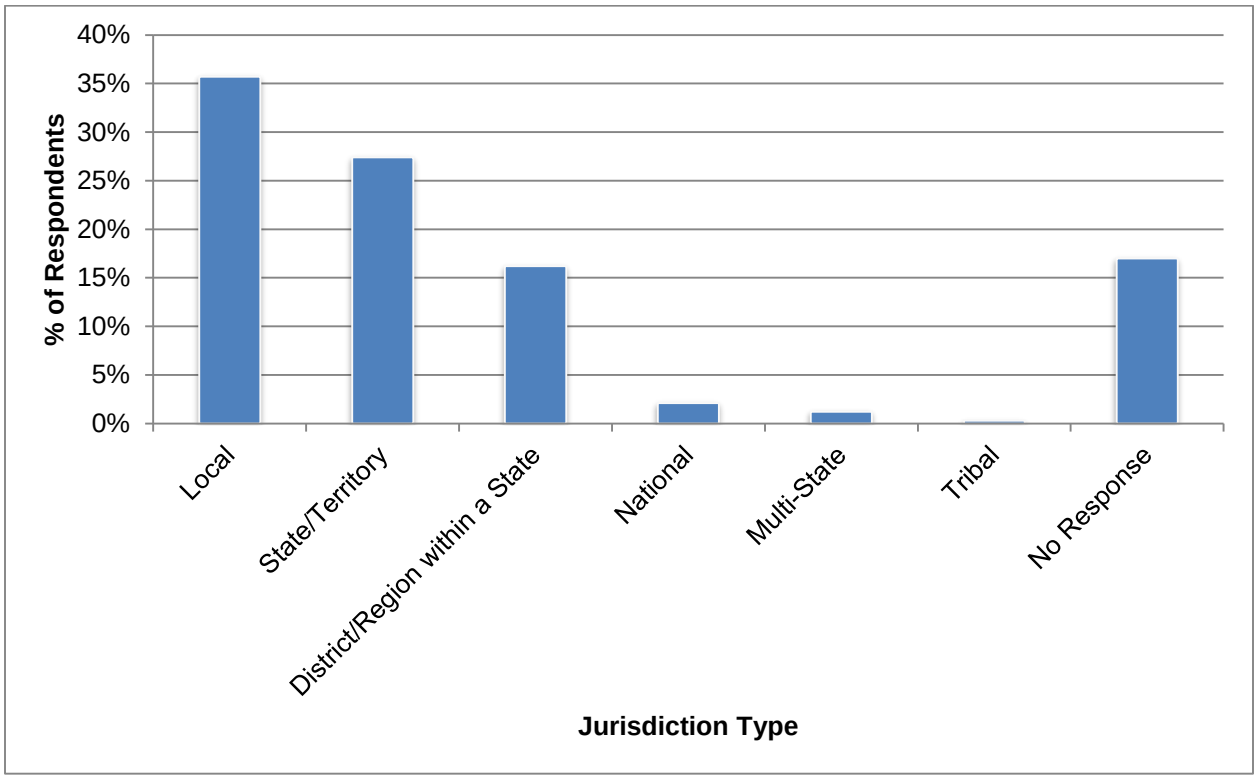
Jurisdiction Type and Size

Respondents were most likely to work in organizations serving local jurisdictions (36%; n=4,158), followed by state or territorial jurisdictions (27%; n=3,185) and districts or regions within a state (16%; n=1,887). Few respondents were employed by national organizations (2%; n=249) or those serving multi-state (1%; n=141) or tribal (<1%; n=40) areas.

Table 12. Type of Jurisdiction Served by Survey Respondents (n=11,640)

Type of Jurisdiction	Number (Percent)
Local	4,158 (35.7%)
State/Territory	3,185 (27.4%)
District/Region within a State	1,887 (16.2%)
National	249 (2.1%)
Multi-State	141 (1.2%)
Tribal	40 (0.3%)
No Response	1,980 (17.0%)

Figure 11. Type of Jurisdiction Served by Survey Respondents (n=11,640)



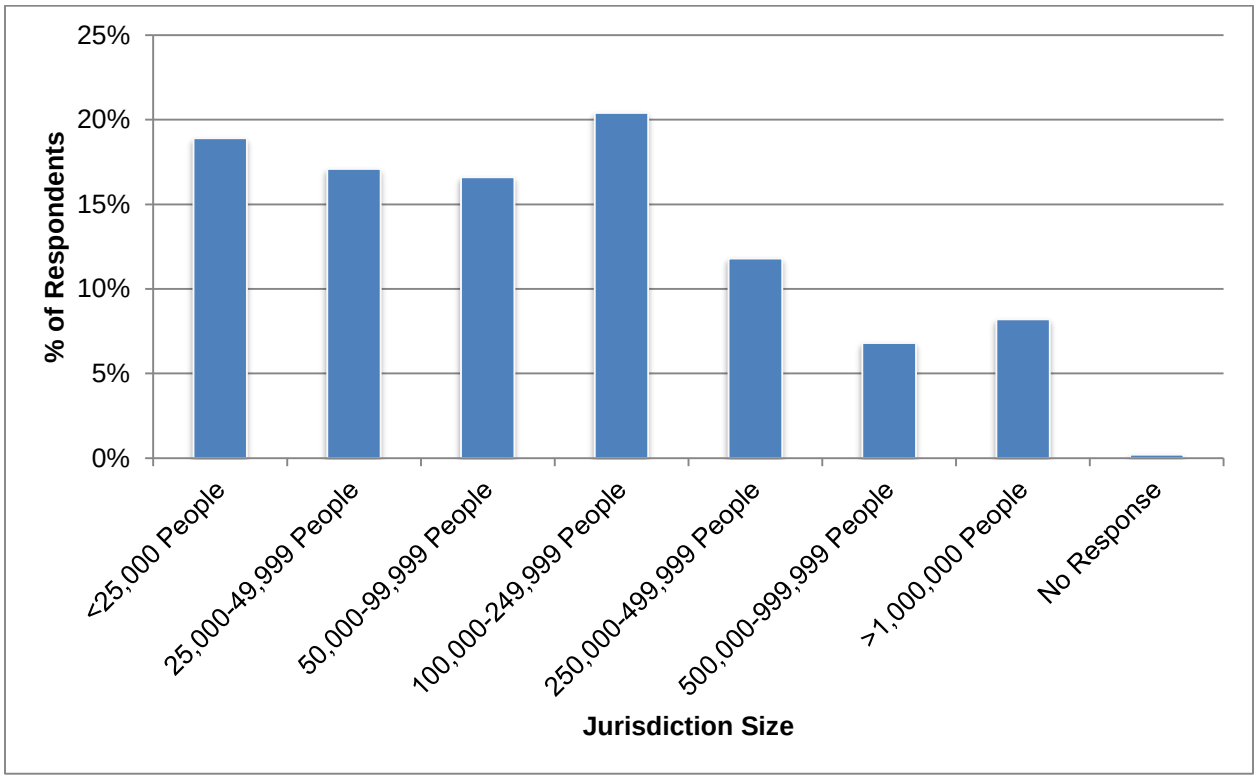
Of the 6,085 respondents employed by organizations operating at local, district/region within a state, or tribal levels, 36% (n=2,192) worked in organizations serving fewer than 50,000 people. Conversely, 8% (n=496) of respondents working at these levels served jurisdictions with populations over 1 million.

Table 13. Size of Jurisdiction Served by Survey Respondents (n=6,085*)

Jurisdiction Size	Number (Percent)
<25,000 People	1,149 (18.9%)
25,000-49,999 People	1,043 (17.1%)
50,000-99,999 People	1,012 (16.6%)
100,000-249,999 People	1,243 (20.4%)
250,000-499,999 People	715 (11.8%)
500,000-999,999 People	415 (6.8%)
>1,000,000 People	496 (8.2%)
No Response	12 (0.2%)

* Data collected from respondents working for local, district/region within a state, and tribal employers only.

Figure 12. Size of Jurisdiction Served by Survey Respondents (n=6,085*)



* Data collected from respondents working for local, district/region within a state, and tribal employers only.

Governmental Public Health

The Council on Linkages has been particularly concerned about recruitment and retention of workers in governmental public health agencies. As a result of this concern, the survey included several questions designed specifically for governmental public health workers. These questions explored how long individuals were employed in governmental public health agencies, including for their current employers, and their locations prior to entering the governmental public health workforce.

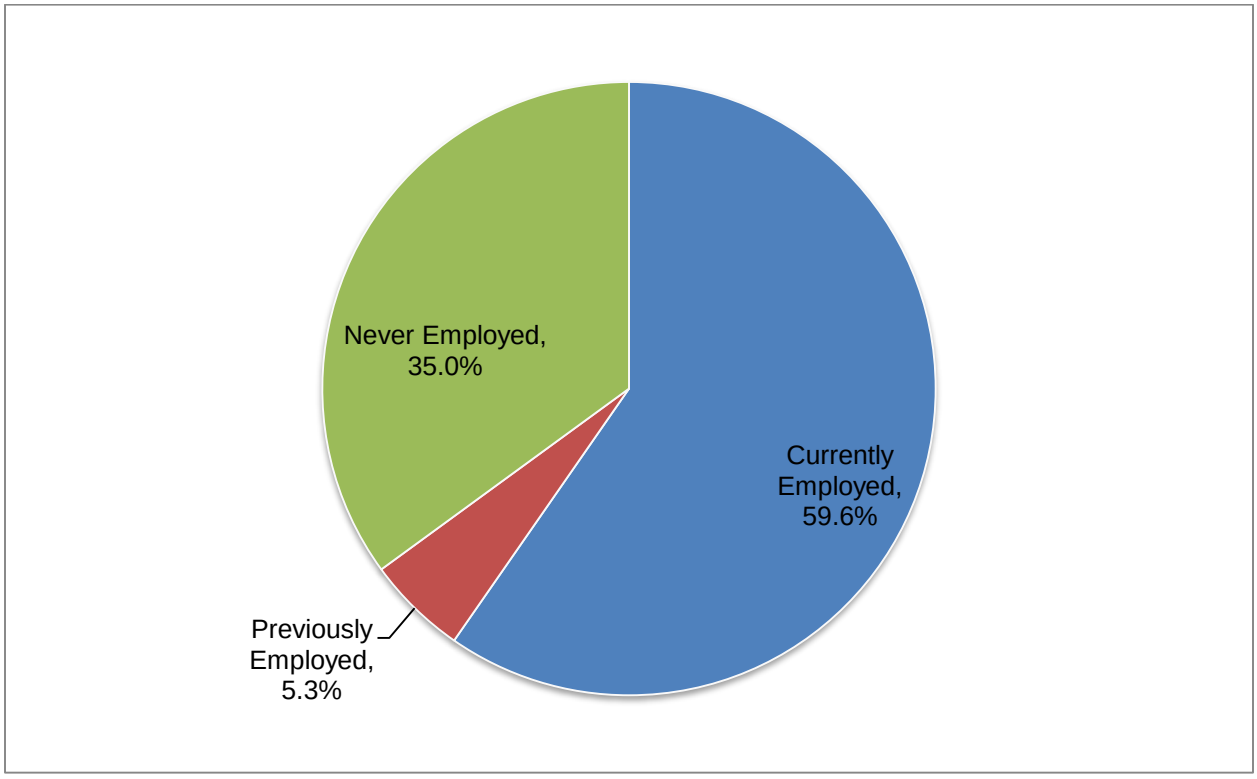
Employment in Governmental Public Health

The majority of survey respondents had been employed by a governmental public health agency at some time in their careers (65%; n=7,560). Of those who indicated that they had ever worked in governmental public health, 92% (n=6,939; 60% of all respondents) continued to do so at the time of the survey.

Table 14. Employment in Governmental Public Health (n=11,640)

Employment in Governmental Public Health	Number (Percent)
Ever Employed	7,560 (64.9%)
Currently Employed	6,939 (59.6%)
Previously Employed	621 (5.3%)
Never Employed	4,076 (35.0%)
No Response	4 (<0.1%)

Figure 13. Employment in Governmental Public Health (n=11,640)



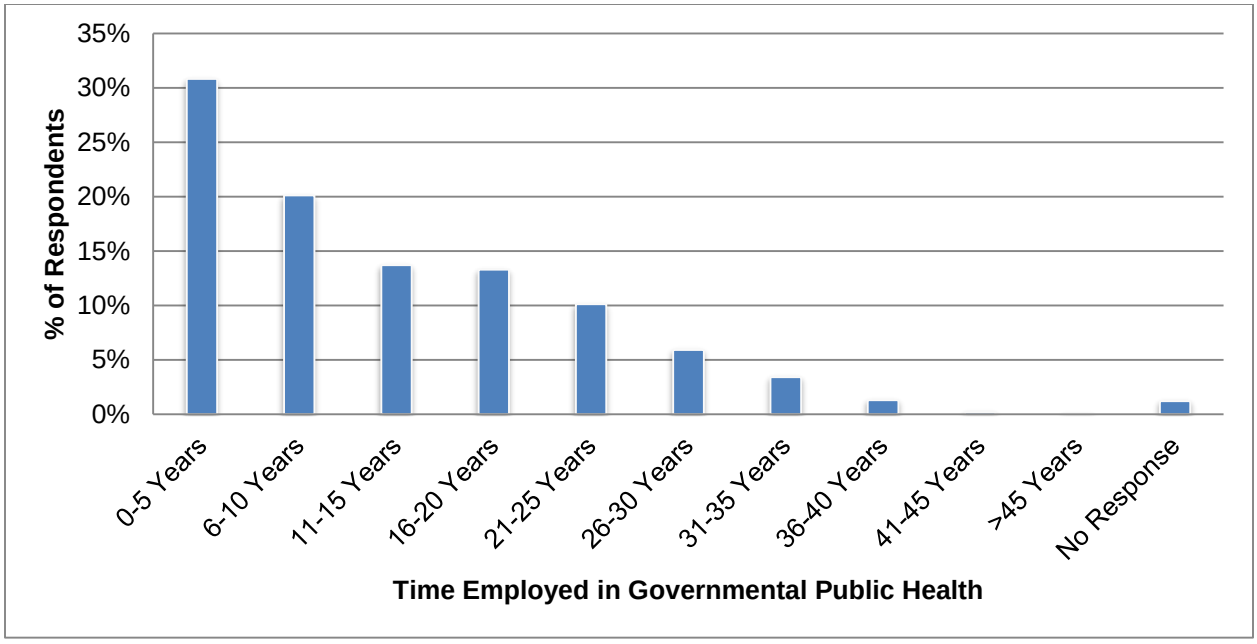
Length of Employment in Governmental Public Health

The average length of governmental employment among respondents who had ever worked for a governmental public health agency was 13 years, with reported length of governmental service ranging from 0 to 55 years. Approximately 31% of these respondents (n=2,327) had worked in governmental public health for five years or less. Forty-eight percent (n=3,623) had been employed in governmental public health for more than 10 years.

Table 15. Length of Employment in Governmental Public Health (n=7,560)

Time Employed in Governmental Public Health	Number (Percent)
0-5 Years	2,327 (30.8%)
6-10 Years	1,517 (20.1%)
11-15 Years	1,038 (13.7%)
16-20 Years	1,003 (13.3%)
21-25 Years	760 (10.1%)
26-30 Years	445 (5.9%)
31-35 Years	259 (3.4%)
36-40 Years	97 (1.3%)
41-45 Years	18 (0.2%)
>45 Years	3 (<0.1%)
No Response	93 (1.2%)

Figure 14. Length of Employment in Governmental Public Health (n=7,560)



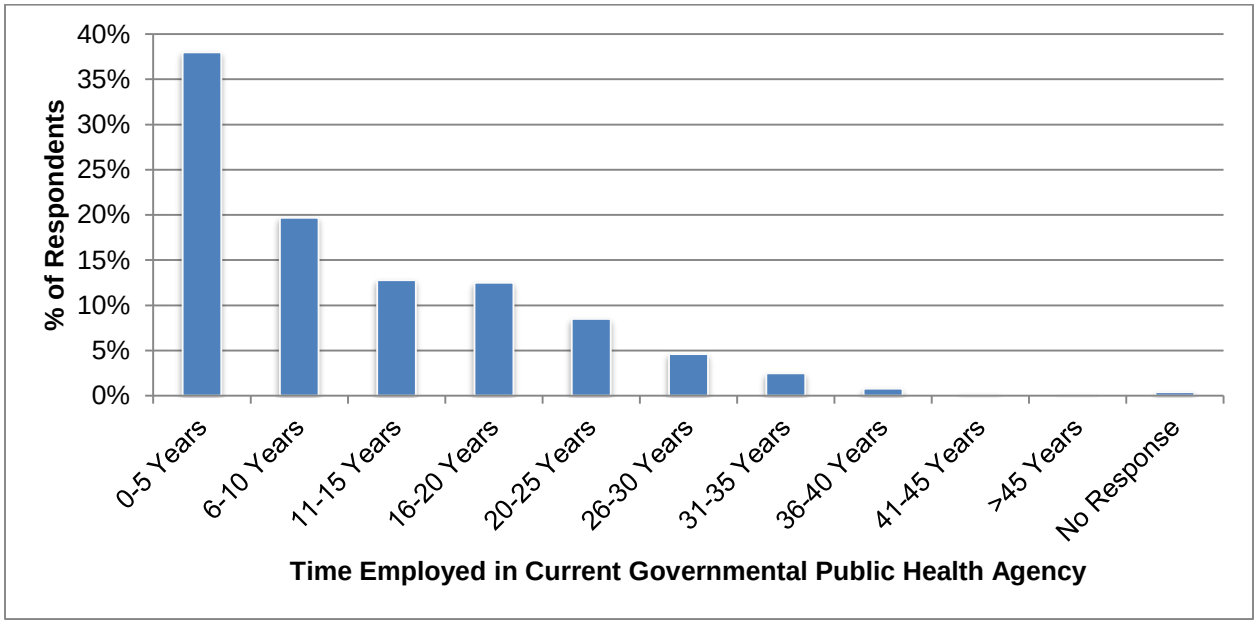
Length of Employment in Current Governmental Public Health Agency

Among respondents employed by governmental public health agencies at the time of the survey, the average length of employment with their current agencies was 11 years. Thirty-eight percent of respondents (n=2,637) had worked for their current employers for five years or less, while 42% (n=2,902) had done so for more than 10 years.

Table 16. Length of Employment in Current Governmental Public Health Agency (n=6,939)

Time Employed in Current Governmental Public Health Agency	Number (Percent)
0-5 Years	2,637 (38.0%)
6-10 Years	1,370 (19.7%)
11-15 Years	890 (12.8%)
16-20 Years	865 (12.5%)
20-25 Years	588 (8.5%)
26-30 Years	317 (4.6%)
31-35 Years	176 (2.5%)
36-40 Years	55 (0.8%)
41-45 Years	10 (0.1%)
>45 Years	1 (<0.1%)
No Response	30 (0.4%)

Figure 15. Length of Employment in Current Governmental Public Health Agency (n=6,939)



Location Prior to Entering Governmental Public Health

Respondents reported entering governmental public health from a variety of settings. The most common prior setting was healthcare services (31%; n=2,368), followed by private industry (23%; n=1,723). Slightly more than 10% of respondents (n=786) were employed by other governmental agencies immediately prior to joining the governmental public health workforce.

Educational programs were also a common prior setting for respondents working in governmental public health. Thirty-three percent of respondents (n=2,520) reported entering governmental public health from educational programs, with 10% of respondents (n=729) coming from degree programs specifically in public health.

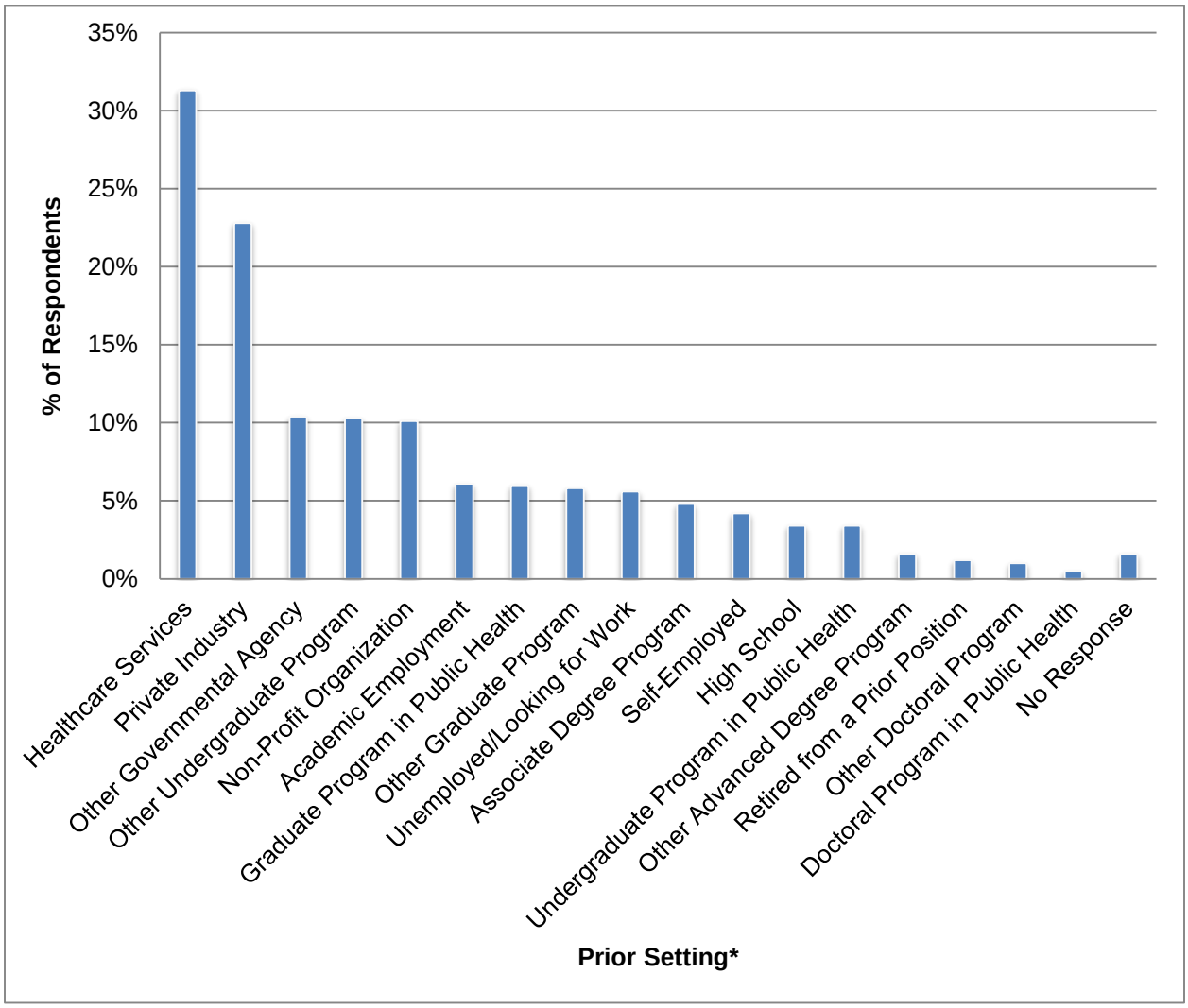
Twenty-two percent (n=1,656) of respondents reported multiple prior locations, with healthcare services and private industry being the most common combination (n=270).

Table 17. Location Prior to Entering Governmental Public Health (n=7,560)

Prior Setting*	Number (Percent)
Healthcare Services	2,368 (31.3%)
Private Industry	1,723 (22.8%)
Other Governmental Agency	786 (10.4%)
Other Undergraduate Program	780 (10.3%)
Non-Profit Organization	762 (10.1%)
Academic Employment	461 (6.1%)
Graduate Program in Public Health	456 (6.0%)
Other Graduate Program	442 (5.8%)
Unemployed/Looking for Work	421 (5.6%)
Associate Degree Program	360 (4.8%)
Self-Employed	314 (4.2%)
High School	255 (3.4%)
Undergraduate Program in Public Health	255 (3.4%)
Other Advanced Degree Program (e.g., MD, JD, etc.)	121 (1.6%)
Retired from a Prior Position	88 (1.2%)
Other Doctoral Program	79 (1.0%)
Doctoral Program in Public Health	36 (0.5%)
No Response	119 (1.6%)

* Respondents could select multiple options.

Figure 16. Location Prior to Entering Governmental Public Health (n=7,560)



* Respondents could select multiple options.

Recruitment and Retention

To explore recruitment and retention, survey respondents were asked to indicate how much a variety of factors influenced their decisions to begin working for their current employers and to continue working for those employers. Both factors related to the organizations in which public health workers are employed and personal factors were considered, and respondents rated the influence of factors on a scale from 0 (no influence) to 10 (a lot of influence).

Organizational Factors

Twelve organizational factors that may influence public health workers' employment decisions were explored. Survey respondents rated each of these factors on a scale of 0 (no influence) to 10 (a lot of influence) in terms of its impact on their initial decisions to work for their current employers as well as their decisions to remain working for their current employers. Mean ratings and standard deviations were calculated.

Among the strongest organizational influences on survey respondents' decisions to begin working for their current employers were the *specific work functions or activities involved in the current position* (6.9 average rating), *job security* (6.8 average rating), *competitive benefits* (6.7 average rating), and *identifying with the mission of the organization* (6.5 average rating). Similar factors were identified as influential in the decision to remain with those employers, with *job security* receiving the highest average rating at 7.4, followed by the *specific work functions or activities involved in the current position* (6.9 average rating), *competitive benefits* (6.7 average rating), *identifying with the mission of the organization* (6.7 average rating), and *flexibility of work schedule* (6.2 average rating).

The *ability to telecommute* received the lowest average ratings in terms of both recruitment and retention (1.3 and 1.9, respectively), followed by having an *immediate opportunity for advancement or promotion* (3.7 and 3.3, respectively). Factors such as *ability to innovate*, *competitive salary*, and *future opportunities for promotion* fell somewhere in between for both recruitment and retention.

Table 18. Organizational Factors Influencing Decision to Work for Current Employer and to Remain Working for Current Employer (n=11,640*)

Organizational Factor	Factors Influencing Recruitment Mean (SD)	Factors Influencing Retention Mean (SD)
Specific work functions or activities involved in current position	6.90 (2.76)	6.90 (2.91)
Job security	6.75 (3.15)	7.39 (3.01)
Competitive benefits	6.70 (3.18)	6.73 (3.29)
Identifying with the mission of the organization	6.49 (3.11)	6.67 (3.13)
Future opportunities for training/continuing education	5.81 (3.21)	5.83 (3.35)
Flexibility of work schedule	5.42 (3.56)	6.23 (3.51)
Ability to innovate	5.30 (3.27)	5.62 (3.36)
Competitive salary	4.76 (3.38)	4.97 (3.43)
Future opportunities for promotion	4.74 (3.36)	4.00 (3.54)
Autonomy/Employee empowerment	4.26 (3.44)	5.04 (3.58)
Immediate opportunity for advancement/promotion	3.70 (3.21)	3.30 (3.27)
Ability to telecommute	1.31 (2.64)	1.91 (3.16)

* Response rates for each factor ranged from 87.3% to 91.9%.

Personal Factors

Survey respondents were also asked about seven personal factors influencing their decisions to begin and continue working for their current employers. As with organizational factors, similar factors seemed to play a role in both recruitment and retention. Respondents rated *enjoy living in the area* (6.1 average rating), *personal commitment to public service* (6.1 average rating), *wanted to live close to family and friends* (5.9 average rating), and *wanted a job in the public health field* (5.8 average rating) as the personal factors most strongly influencing their decisions to begin working for their current employers. These same factors received the highest ratings in terms of deciding to remain working for those employers, although *personal commitment to public service* was given the highest average rating for retention, followed by *enjoy living in the area* (6.6 and 6.5 average ratings, respectively). For both recruitment and retention, having a *family member or role model working in public health* did not appear to be a strong influence on employment decisions.

Table 19. Personal Factors Influencing Decision to Work for Current Employer and to Remain Working for Current Employer (n=11,640*)

Personal Factor	Factors Influencing Recruitment Mean (SD)	Factors Influencing Retention Mean (SD)
Enjoy living in the area (e.g., climate, amenities, culture)	6.13 (3.63)	6.53 (3.61)
Personal commitment to public service	6.12 (3.30)	6.62 (3.22)
Wanted to live close to family and friends	5.86 (3.99)	6.22 (3.84)
Wanted a job in the public health field	5.82 (3.62)	6.09 (3.56)
Needed a job, but it didn't matter if it was in public health	3.89 (3.72)	3.53 (3.66)
Wanted to work with specific individual(s)	3.27 (3.48)	5.12 (3.73)
Family member/role model was/is working in public health	1.69 (3.00)	1.63 (2.96)

* Response rates for each factor ranged from 87.5% to 91.1%.

Comparing Organizational and Personal Factors

When looking across organizational and personal factors, four of the five highest scoring factors for both recruitment and retention were organizational rather than personal. These organizational factors included the *specific work functions or activities involved in the current position*, *job security*, *competitive benefits*, and *identifying with the mission of the organization*. These factors were joined by *enjoying living in the area* in terms of recruitment and *personal commitment to public service* for retention.

In addition, the majority of both organizational and personal factors were rated more highly in terms of their influence on decisions to remain working for employers than on decisions to take jobs with those employers initially. The only factors with lower average scores for retention compared to recruitment were *future opportunities for promotion* and *immediate opportunity for advancement/promotion*, among organizational factors, and *needed a job, but it didn't matter if it was in public health* and *family member/role model was/is working in public health*, among personal factors.

Organizational Environment

The environments in which individuals work can play an important role in job satisfaction, and factors related to organizational environment can influence employee recruitment and retention. To explore organizational environment, survey respondents were asked to react to 17 positive statements about characteristics of the environments in which they work. Statements considered aspects of leadership, management, and professional development, and respondents indicated how strongly they agreed or disagreed with the statements using a five-point Likert scale.

Leadership

Organizational leadership was explored with statements addressing trust and mutual respect, shared vision, professional standards, performance evaluations, and feedback. Overall, respondents were generally favorable toward organizational leadership, with more than half strongly or somewhat agreeing with the six positive statements presented (agreement ranged from 51-65% across the statements). Respondents were most likely to agree that *employees are held to high professional standards for the work they do*, with 65% of respondents (n=6,727) agreeing with this statement. However, more than a quarter of respondents disagreed with each of the other five positive statements about leadership within their organizations (disagreement ranged from 22-33% across all statements). Respondents most strongly disagreed that *there is an atmosphere of trust and mutual respect within the organization*, with 33% of respondents (n=3,435) indicating that they somewhat or strongly disagreed with this statement.

Table 20. Perceptions of Organizational Leadership (n=11,640*)

Organizational Leadership	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
There is an atmosphere of trust and mutual respect within the organization (n=10,402)	2,247 (21.6%)	3,553 (34.2%)	1,167 (11.2%)	1,958 (18.8%)	1,477 (14.2%)
Management and staff have a shared vision (n=10,392)	2,018 (19.4%)	3,746 (36.0%)	1,427 (13.7%)	1,944 (18.7%)	1,257 (12.1%)
Employees are held to high professional standards for the work they do (n=10,381)	3,211 (30.9%)	3,516 (33.9%)	1,332 (12.8%)	1,384 (13.3%)	938 (9.0%)
Employee performance evaluations are handled in an appropriate manner (n=10,381)	2,442 (23.5%)	3,051 (29.4%)	1,990 (19.2%)	1,624 (15.6%)	1,274 (12.3%)
The procedures for employee performance evaluations are consistent (n=10,371)	2,414 (23.3%)	2,893 (27.9%)	2,030 (19.6%)	1,628 (15.7%)	1,406 (13.6%)
Employees receive constructive feedback that can help them improve their performance (n=10,381)	2,206 (21.3%)	3,447 (33.2%)	1,869 (18.0%)	1,596 (15.4%)	1,263 (12.2%)

* Response rates for each statement ranged from 89.1% to 89.4%.

Management

A further six statements reflected areas of management, and respondents were asked to indicate their level of agreement that management within their organizations had made a sustained effort over the past 12 months to address employee concerns about tools, professional development, autonomy/employee empowerment, leadership issues, support for new employees, and safety and security. As with organizational leadership, respondents were generally favorable toward organizational management, with approximately half indicating that they strongly or somewhat agreed with all six positive statements (agreement ranged from 45-64% across the statements). Respondents most strongly agreed that management has made a sustained effort to address employee concerns about *safety and security*, with 64% of respondents (n=6,570) agreeing with this statement, and about *tools needed to do the job* (63% agreement; n=6,463).

However, similar to the findings regarding aspects of organizational leadership, up to a third of respondents disagreed with the positive statements presented (disagreement ranged from 14-32% across the statements). Respondents most strongly disagreed that management has made a sustained effort to address employee concerns about *leadership issues*, with 32% of respondents (n=3,259) indicating that they somewhat or strongly disagreed with that statement. Twenty-nine percent (n=2,938) disagreed that management had addressed concerns about *autonomy/employee empowerment*.

Table 21. Perceptions of Management Efforts to Address Employee Concerns (n=11,640*)

Organizational Management	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Tools needed to do my job (n=10,334)	2,698 (26.1%)	3,765 (36.4%)	1,562 (15.1%)	1,393 (13.5%)	916 (8.9%)
Professional development (n=10,306)	2,520 (24.5%)	3,628 (35.2%)	1,697 (16.5%)	1,415 (13.7%)	1,046 (10.1%)
Autonomy/Employee empowerment (n=10,307)	1,777 (17.2%)	3,022 (29.3%)	2,570 (24.9%)	1,609 (15.6%)	1,329 (12.9%)
Leadership issues (n=10,295)	1,703 (16.5%)	2,974 (28.9%)	2,359 (22.9%)	1,746 (17.0%)	1,513 (14.7%)
New employee support (n=10,289)	1,869 (18.2%)	3,104 (30.2%)	2,995 (29.1%)	1,324 (12.9%)	997 (9.7%)
Safety and security (n=10,303)	2,885 (28.0%)	3,685 (35.8%)	2,286 (22.2%)	830 (8.1%)	617 (6.0%)

* Response rates for each statement ranged from 88.4% to 88.8%.

Professional Development

Finally, respondents were presented with five positive statements about professional development within their organizations related to aspects of funding, time, technology training, peer learning, and knowledge and skill development. Level of agreement with these statements varied widely, from 36-66% agreement across the statements. The most agreement was with the statement that *employees are provided with opportunities to learn from one another* (66%; n=6,793), followed by *professional development provides employees with the knowledge and skills most needed to do their work effectively* (60%; n=6,127). Disagreement also ranged widely, from 18-51% across the statements. Fifty-one percent of respondents (n=5,177) disagreed that *sufficient funds and resources are available to allow employees to take advantage of professional development opportunities*.

Table 22. Perceptions of Professional Development (n=11,640*)

Professional Development	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Sufficient funds and resources are available to allow employees to take advantage of professional development opportunities (n=10,253)	1,104 (10.8%)	2,625 (25.6%)	1,347 (13.1%)	2,548 (24.9%)	2,629 (25.6%)
Adequate time is provided for professional development (n=10,240)	1,523 (14.9%)	3,063 (29.9%)	1,717 (16.8%)	2,204 (21.5%)	1,733 (16.9%)
Employees have sufficient training to fully utilize technology needed for their work (n=10,218)	1,557 (15.2%)	3,366 (32.9%)	1,733 (17.0%)	2,299 (22.5%)	1,263 (12.4%)
Employees are provided with opportunities to learn from one another (n=10,242)	2,435 (23.8%)	4,358 (42.6%)	1,616 (15.8%)	1,195 (11.7%)	638 (6.2%)
Professional development provides employees with the knowledge and skills most needed to do their work effectively (n=10,218)	2,399 (23.5%)	3,728 (36.5%)	1,936 (18.9%)	1,359 (13.3%)	796 (7.8%)

* Response rates for each statement ranged from 87.8% to 88.1%.

Implications and Conclusions

The public health workforce represents a critical element of the nation's health system, and ensuring a sufficient, capable workforce is key to ensuring the health of Americans. In conducting this survey, the Council on Linkages aimed to contribute to the information available about the individuals who participate in the public health workforce and their reasons for doing so. Greater access to this type of information can begin providing a foundation on which to base strategies for recruiting and retaining public health workers. The findings presented in this report suggest a number of potential considerations for public health policymakers, leaders, managers, and others involved in workforce initiatives.

Age of Public Health Workers

In general, survey respondents tended to be closer to the end of their careers than the beginning. The average age of public health workers responding to this survey was 47, with the youngest being 18 and the oldest 83. More than half (58%) were 45 or older, with 28% being 55 or older. Only 15% were under the age of 35. In addition, approximately half of the respondents had been employed in public health for more than 10 years, with nearly one-quarter working in public health for more than 20 years. Effective mechanisms for recruiting individuals into public health may become more and more critical as the existing workforce ages and enters retirement.

Diversity of Public Health Workers

For any profession serving a diverse public, diversity of the workforce is an important consideration, and there appears to be limited diversity among the public health workers responding to this survey. Significant majorities of respondents identified as female, White, and non-Hispanic, suggesting room for improvement in ensuring the diversity of the workforce is well matched to the public it serves.

Public Health Education

Relatively few survey respondents completed their education with degrees specifically in public health. While 55% of these public health workers held bachelor's, master's, or doctoral degrees at the start of their public health careers, only 9% of those indicated that their highest degrees earned were in public health. This percentage had increased by the time of the survey, but still remained relatively low: 58% of workers had now earned bachelor's, master's, or doctoral degrees, with 11% reporting their highest degrees were in public health.

The relative lack of public health degrees reported by survey respondents also did not indicate a lack of education in general. The most common level of education among respondents was a bachelor's degree. Both at entry into the field of public health and at the time of the survey, approximately one-third of respondents indicated that they had completed bachelor's degrees, while another 22% held more advanced degrees upon entering public health. This percentage increased over time, with approximately 31% completing these types of advanced degrees by the time of the survey.

Nearly one in five survey respondents continued their formal education after beginning work in the field. In comparing education levels at the start of their public health careers and at the time of the survey, 18% of respondents indicated continuing their education in some manner.

Employment Beyond Governmental Public Health

Public health may traditionally be thought of as the domain of government, and it is true that more respondents reported employment in various levels of government (71%) than in any other setting. However, a significant number of respondents (22%) reported working in multiple settings, and 24% worked exclusively outside of governmental settings. The most common non-governmental setting reported by respondents was healthcare services (26%). It is important to take into consideration the variety of settings in which the work of public health may be accomplished in discussing issues of recruitment and retention within the field.

Recruit from Healthcare, Private Industry, Academic Programs

Healthcare settings, as well as private industry, may provide opportunities for recruiting workers into governmental public health. While there may be a tendency to think of people leaving governmental public health for more lucrative jobs in healthcare and the private sector, the reverse also seems to occur – for respondents entering governmental public health, approximately 31% came from healthcare services and 23% from private industry. Comparatively, few respondents moved into governmental public health from other governmental agencies (10%), non-profit organizations (10%), or academia (6%). Creating opportunities for qualified professionals to move between healthcare, private industry, and governmental public health and looking for potential hires outside of the public sector may help with recruitment.

An additional opportunity for recruitment may be presented by academic programs, as 33% of respondents indicated entering public health directly from educational programs, although not necessarily from public health programs. Involving educational institutions in recruitment efforts may be beneficial; however, efforts could reach beyond schools and programs of public health: only 10% of respondents reported coming into governmental public health from public health degree programs.

Importance of Nursing

In this study, nurses accounted for one in four survey respondents. As is apparent in the diversity of educational backgrounds and professional roles held by public health workers responding to this survey, public health as a field encompasses a wide variety of specialties. However, one profession in particular stands out – nursing. Fully 26% of respondents indicated that their primary professional role was as a nurse. With the exception of administrative and management positions, this percentage was more than double that of any other role reported on the survey. In addition, when workers served in multiple roles, they were most likely to be involved in nursing as well as administration or management. The number of nurses present among survey respondents may influence other findings of this survey, such as the relatively low percentage of public health degree holders and relatively high percentages of individuals who work in healthcare or who entered governmental public health from healthcare settings.

Keys to Recruiting and Retaining Public Health Workers

In general, survey results indicated that the factors influencing respondents' decisions to begin working for employers were the same factors that were important in their decisions to continue working for those employers. While the relative importance of individual factors may have changed over time, the types of factors deemed important remained fairly static.

In addition, the factors that survey respondents valued in making employment decisions tended to be organizational more than personal. Of the 19 organizational or personal factors presented to respondents, four of the five highest scoring factors for both recruitment and retention were organizational, and therefore, were factors that organizations have more ability to influence. These included the specific activities involved in a position, job security, competitive benefits, and identifying with the mission of the organization.

Linking Workers to the Public Health Mission

Linking workers to the vision and mission of public health may support recruitment and retention. Several influential factors in respondents' decisions to begin and continue working for employers were intricately tied to individuals' feelings regarding the nature of public health work. The specific activities involved in a position, identifying with the mission of the organization, having a personal commitment to public service, and wanting a job in the public health field all received high ratings for their influence on employment decisions. Emphasizing the importance of an organization's mission and activities and the value of that organization in improving the public's health may prove beneficial in enhancing recruitment and retention efforts. Further, finding ways to highlight and be specific about the types of tasks that public health positions entail may help in recruiting individuals well-suited to positions; student internships may offer one such way of introducing potential future employees to the specific work activities involved in public health.

Focus on Job Security and Benefits Rather than Salary

In planning recruitment and retention efforts, it may be more effective to focus on job security and benefits than on salary. Among the most influential factors reported by respondents for both recruitment and retention were job security and competitive benefits, both of which received higher average ratings than competitive salaries. There can often be a tendency to focus on salary when discussing recruitment and retention, but this survey identified several other factors that respondents valued in making employment decisions. While public health may not be able to offer the highest salaries in the market, there are other draws, such as job security and benefits packages, that can be emphasized in recruitment efforts.

Cuts to Benefits Harmful

Cuts to benefit packages may negatively impact recruitment and retention within public health. Given the reported importance of competitive benefits in terms of respondents' employment decisions, future recruitment and retention efforts may be harmed if organizations cut back on benefits. If job security and benefits packages are to be used as significant recruitment and

retention factors for public health, these need to be maintained at levels comparable to or exceeding those found in related fields.

Importance of Professional Development

Although survey respondents rated opportunities for training or continuing education as fairly important in their decisions to enter and remain working in public health positions, attention to and resources for professional development appeared to be less than desirable. With respect to professional development within their organizations, respondents indicated being less than satisfied with the level of funds and resources available to allow them to take advantage of professional development opportunities. As well, approximately 38% of respondents reported not having adequate time for professional development and 35% felt they did not have sufficient training to fully utilize the technology needed to perform their jobs. This suggests a gap in strategies for supporting professional development and a need for organizations to find efficient ways to provide more professional development opportunities. Improving and emphasizing training and educational opportunities may help attract individuals to careers in public health and retain them within those careers.

As well, the number of survey respondents entering governmental public health directly from educational programs in areas other than public health and the relatively low levels of formal public health education reported by respondents, combined with the high levels of dissatisfaction related to aspects of professional development, suggest that there may be opportunities to strengthen options for continuing education and training aimed at building public health skills within the workforce. To ensure an effective workforce, the development of public health competencies and skills cannot be considered solely the responsibility of academic public health programs, but should be prioritized within public health practice organizations as well.

Build Leadership and Management Skills

By focusing on building leadership and management skills, public health organizations may be able to positively impact recruitment and retention through actions that do not require substantial additional funding. While job security, salary, and benefits all have roles to play in employment decisions, the environment in which people work can significantly impact their satisfaction with and desire to remain in their jobs. Responses to statements about leadership and management within public health organizations indicated room for improvement. For the areas considered, on average, approximately 25% of respondents disagreed with the positive statements presented, with particularly high levels of dissatisfaction related to the perception of an atmosphere of trust and mutual respect, management efforts to deal with leadership issues, the feeling that management and staff have a shared vision, consistency in procedures for employee performance evaluations, and management efforts to address employee concerns about autonomy or employee empowerment. Strengthening leadership and management skills could help to improve organizational environments and retain employees.

Using TRAIN for Research

Beyond contributing information about individuals who participate in the public health workforce to inform recruitment and retention efforts, this study presented an important opportunity to

explore using TRAIN for public health services and systems research. TRAIN represents the largest repository of individual-level data on public health workers in the US[7-8], offering researchers an avenue for studying this workforce at the individual worker level. TRAIN can be used to learn more about the current public health workforce and its skills, competence, and training; several tailored TRAIN datasets[8] are available for use by researchers, and customized data can be requested to meet specific research needs. As of December 2015, TRAIN has grown to include over 1 million registered users.

Future Directions

The Council on Linkages' survey of public health workers represents an important step in learning about the employment decisions of public health workers to better enable the development of evidence-supported recruitment and retention strategies. This survey provides considerable data for building and strengthening programs aimed at attracting and keeping workers in the public health field. These data are available to researchers by request to PHWorkforce@phf.org and have formed the basis for subsequent analyses and publications.[9-10] Additional data collection over time, such as that which occurred through the 2014 Public Health Workforce Interests and Needs Survey[11], will help continue to enhance the knowledgebase about public health employment factors. Further efforts are also needed to create and implement specific recruitment and retention strategies and evaluate these strategies to determine if they have a positive impact on attracting workers, retaining workers, and promoting a more satisfied and effective workforce.

For More Information

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Appendix: Council on Linkages' Survey of Public Health Workers

COUNCIL ON LINKAGES BETWEEN ACADEMIA AND PUBLIC HEALTH PRACTICE

Version 21

PUBLIC HEALTH WORKFORCE SURVEY

BE A PART OF HISTORY—LET YOUR VOICE BE HEARD!!!

The Council on Linkages Between Academia and Public Health Practice (Council) is conducting this survey in order to determine how, when, and why individuals enter, stay in, and leave the public health workforce. Your participation and perspectives will help us strengthen our nation's public health workforce.

A survey of this nature has never been attempted before! The information you provide will assist the Council and other organizations with developing effective recruitment and retention strategies for the US public health system. The survey mainly focuses on governmental public health because this is where public health worker shortages are most critical. However, it is important for us to hear from you even if you are not working in governmental public health!

At the end of the survey, you will have an opportunity to enter a raffle to win gift certificates and other prizes. **Click here** for more information!

INSTRUCTIONS: Click Here to start the survey.

PLEASE NOTE:

- Your responses to the survey questions are voluntary and will be confidential
- There are 14-28 questions total (and only one open-ended question)
- It should take you approximately 15-20 minutes to complete the survey
- You do not need to complete the survey in one sitting - you can return to the survey site multiple times

QUESTIONS? Email: PHworkforce@phf.org.

Privacy Policy

The Council on Linkages Between Academia and Public Health Practice is comprised of 17 organizations:

American Public Health Association (APHA)
American College of Preventive Medicine (ACPM)
Association for Prevention Teaching and Research (APTR)
Association of Schools of Public Health (ASPH)
Association of State and Territorial Health Officials (ASTHO)
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 of 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)
Quad Council of Public Health Nursing Organizations (Quad Council)
Society for Public Health Education (SOPHE)

We thank the TRAIN community for allowing us to survey its users!

1. **How many years have you been employed as a public health professional (e.g. government, private organization, academia)?**

   _____

2. **Have you ever been employed by a GOVERNMENTAL public health agency?**
   - o Yes
   - o No (Go to **question #7**)

3. **Are you currently employed by a GOVERNMENTAL public health agency?**
   - o Yes
   - o No (Go to **question #5**)

4. **How many years have you been employed by the GOVERNMENTAL public health agency for which you are currently working?**

   _____

5. **In total, how many years have you spent as an employee of a GOVERNMENTAL public health agency?**

   _____

6. **Where were you immediately prior to entering the GOVERNMENTAL public health workforce? (SELECT ALL THAT APPLY)**
   - o High school
   - o Associate degree program
   - o Undergraduate program in Public Health
   - o Other undergraduate program
   - o Graduate program in Public Health
   - o Other graduate program
   - o Doctoral program in Public Health
   - o Other doctoral program
   - o Other advanced degree program (e.g. MD, JD, etc.)
   - o Other governmental agency
   - o Healthcare services
   - o Nonprofit organization
   - o Private industry
   - o Academic employment

- o Retired from a prior position
- o Self employed
- o Unemployed/Looking for work

7. **What is your current work setting (SELECT ALL THAT APPLY):**
   - o Academic institution
   - o Government-federal
   - o Government-state
   - o Government-local
   - o Government-territory
   - o Government-tribal
   - o Healthcare services
   - o Nonprofit organization
   - o Private industry
   - o Self employed **(Go to Demographics section)**

Organizational Factors

8.	**How much did these factors influence your decision to take your first position with your current employer?**	**No Influence 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**A lot of Influence 10**
o	Job security											
o	Flexibility of work schedule											
o	Ability to work from home											
o	Autonomy/Employee empowerment											
o	Specific duties and responsibilities											
o	Identifying with the mission of the organization											
o	Ability to innovate											
o	Immediate opportunity for advancement/promotion											
o	Future opportunities for promotion											
o	Opportunities for training/continuing education											
o	Competitive salary											
o	Competitive benefits											

Personal Factors

9.	**How much did these factors influence your decision to take your first position with your current employer?**	**No Influence 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**A lot of Influence 10**
o	Enjoy living in the area (e.g. climate, amenities, culture)											
o	Wanted to live close to family and friends											
o	Wanted to work with specific individual(s)											
o	Wanted a job in the public health field											
o	Needed a job, but it didn't matter if it was in public health											
o	Personal commitment to public service											
o	Family member/role model was/is working in public health											

Organizational Factors

10.	**How much do these factors influence your decision to remain with your current employer?**	**No Influence 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**A lot of Influence 10**
o	Job security											
o	Flexibility of work schedule											
o	Ability to work from home											
o	Autonomy/Employee empowerment											
o	Specific duties and responsibilities											
o	Identifying with the mission of the organization											
o	Ability to innovate											
o	Immediate opportunity for advancement/promotion											
o	Future opportunities for promotion											
o	Opportunities for training/continuing education											
o	Competitive salary											
o	Competitive benefits											

Personal Factors

11.	**How much do these factors influence your decision to remain with your current employer?**	**No Influence 0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**A lot of Influence 10**
o	Enjoy living in the area (climate, amenities, culture, etc.)											
o	Want to live close to family and friends											
o	Want to continue working with specific individual(s)											
o	Want a job in the public health field											
o	Need a job, but it doesn't matter if it is in public health											
o	Personal commitment to public service											
o	Family member/role model was/is working in public health											

12.	**Please rate how strongly you agree or disagree with the following statements about leadership in your organization:**	**Strongly agree**	**Somewhat agree**	**Neither agree nor disagree**	**Somewhat disagree**	**Strongly disagree**
o	There is an atmosphere of trust and mutual respect within the organization					
o	Management and staff have a shared vision					
o	Employees are held to high professional standards for the work they do					
o	Employee performance evaluations are handled in an appropriate manner					
o	The procedures for employee performance evaluations are consistent					
o	Employees receive constructive feedback that can help them improve their performance					
13.	**Over the past 12 months, management in the organization has made a sustained effort to address employee concerns about:**	**Strongly agree**	**Somewhat agree**	**Neither agree nor disagree**	**Somewhat disagree**	**Strongly disagree**
o	Tools needed to do my job					
o	Professional development					
o	Autonomy /Employee empowerment					
o	Leadership issues					
o	New employee support					
o	Safety and security					
14.	**Please rate how strongly you agree or disagree with the following statements about professional development in your organization:**	**Strongly agree**	**Somewhat agree**	**Neither agree nor disagree**	**Somewhat disagree**	**Strongly disagree**
o	Sufficient funds and resources are available to allow employees to take advantage of professional development opportunities					
o	Adequate time is provided for professional development					
o	Employees have sufficient training to fully utilize technology needed for their work					
o	Employees are provided with opportunities to learn from one another					
o	Professional development provides employees with the knowledge and skills most needed to do their work effectively					

DEMOGRAPHICS

Your responses to these questions will help us better understand the characteristics of the individuals completing this survey. Demographic information will **NOT** be linked to any identifier data and will only be used in a summary manner.

15. Gender:

o Male o Female

Questions on race and ethnicity are optional

16. Race (SELECT ALL THAT APPLY):

o American Indian or Alaska Native
o Asian
o Black or African American
o Native Hawaiian or Other Pacific Islander
o White

17. Ethnicity (Hispanic, Latino or Spanish origin):

o Yes
o No

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18. Please enter your age:

_____

19. Primary professional role(s) (SELECT UP TO THREE):

o Administrative Support Staff
o Administrator/Director/Manager
o Allied Health Professional
o Biostatistician/Epidemiologist/Statistician
o Data Analyst
o Environmental Health Specialist
o Emergency Responder/Planner
o Faculty/Educator
o Health Educator

- Laboratory Professional
- Nurse
- Physician
- Public Health Service Provider (non-clinical)
- Researcher
- Student

20. What was the highest level of education you had completed WHEN YOU FIRST BECAME A PUBLIC HEALTH PROFESSIONAL?

- High school
- Associate degree
- Bachelor's degree in Public Health
- Other bachelor's degree
- Master's degree in Public Health
- Other master's degree
- Doctoral degree in Public Health
- Other doctoral degree
- Other advanced degree (e.g. MD, JD, etc.)

21. Current education level (HIGHEST ATTAINED):

- High school
- Associate degree
- Bachelor's degree in Public Health
- Other bachelor's degree
- Master's degree in Public Health
- Other master's degree
- Doctoral degree in Public Health
- Other doctoral degree
- Other advanced degree (e.g. MD, JD, etc.)

22. In your current position you are a:

- Full time employee
- Part time employee
- Contractual worker
- Volunteer

23. State/territory where you WORK:

24. Zip code of where you WORK:

25. The jurisdiction served by your current employer is:

- o Local (e.g. county, municipality, township) (Go to **question #26**)
- o District/region within a state (Go to **question #26**)
- o Tribal
- o State/Territory (Go to **question #27**)
- o Multi-state (Go to **question #27**)
- o National (Go to **question #27**)

26. How large is the jurisdiction served by your organization?

- o <25,000 people
- o 25,000-49,999
- o 50,000-99,999
- o 100,000-249,000
- o 250,000-499,999
- o 500,000-999,999
- o 1,000,000+

27. How large is your organization?

- o Not sure/Unknown
- o Less than 25 people
- o 25-99
- o 100-499
- o 500-999
- o 1,000-9,999
- o 10,000 or more

28. Is there anything else you would like to tell us that we did not ask?

_____

29. Sign me up for the following:

- o A summary of the results of this survey
- o PHF E-News - bringing you the latest ideas and tools for quality improvement and workforce development in public health
- o Hot Off the Press - notices of new learning resources available through the Public Health Foundation online store

30. Enter me in the drawing to win: gift certificates and other prizes! My email address is:

_____

Thank you for taking the survey!!!

9. Supplemental Materials:

- **Council Constitution and Bylaws**
- **Council Participation Agreement**
- **Council Strategic Directions, 2011-2015**

The Council on Linkages Between Academia and Public Health Practice

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, 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.

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 Association of Colleges of Nursing (AACN)
- American College of Preventive Medicine (ACPM)
- American Public Health Association (APHA)
- Association for Prevention Teaching and Research (APTR)
- Association of Accredited Public Health Programs (AAPHP)
- Association of Public Health Laboratories (APHL)
- Association of Schools and Programs of Public Health (ASPPH)
- Association of State and Territorial Health Officials (ASTHO)
- Association of University Programs in Health Administration (AUPHA)
- Centers for Disease Control and Prevention (CDC)
- Community-Campus Partnerships for Health (CCPH)
- Council on Education for Public Health (CEPH) – Preliminary Member Organization
- 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)
- National Public Health Leadership Development Network (NLN)
- Quad Council Coalition of Public Health Nursing Organizations (Quad Council)
- 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.

Adopted: January 24, 2006
Amended: January 27, 2012
Article III.B. Member Organizations Updated: September 6, 2013; March 31, 2014; August 19, 2015; January 20, 2016

The Council on Linkages Between Academia and Public Health Practice

Participation Agreement

The Council on Linkages Between Academia and Public Health Practice (Council) exists 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. In order to fulfill this mission, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council involvement requires that:

- The Member Organization (Organization) selects an appropriate Representative (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 has access to and communicates regularly with the Organization's leadership about Council activities.

- The Representative is able to present the perspectives of the Organization during Council meetings.

- The Representative attends and actively participates in scheduled meetings and does 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.

- The Organization identifies 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, the Representative presents the progress his/her respective Organization and members have made toward implementing and sustaining productive academic/practice linkages.

- The Representative and Organization contribute to the Council's understanding of how Council initiatives and products are being used by the members/constituents of the Council Organization.

- The Representative (or staff contact) responds to requests for assistance with writing and compiling Council documents and resources.

- The Representative and Organization disseminate information on linkage activities using media generally available to the Council's constituency and specifically to the respective membership of the Council Organization.

- Upon request of the Council Chair, the Representative officially represents the Council at meetings or presentations widely attended by members of the practice and academic public health communities.

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

We have read and understand the Participation Agreement described above and agree to the obligations and conditions for membership on the Council on Linkages Between Academia and Public Health Practice. We understand that membership and representation is voluntary, and we may withdraw Representative and/or Organizational participation at any time if we are unable to meet the above outlined responsibilities.

_____	_____
Council Representative Designated by Organization	Date
_____	_____
Organizational Executive Director	Date
_____	
Member Organization	

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
Revised: April 28, 2014

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.

Tactics:

a. Develop an online competency-based training module/plan using existing courses.

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 existing data to better understand the composition and competencies of the public health workforce.
c. Use survey methods to gather additional data about public health workers.

d. Join the Public Health Accreditation Board's Public Health Workforce Think Tank to encourage the integration of competencies into accreditation processes.
e. 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 capacity for 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.