Build a Resilient Equity-Focused Local Public Health Workforce for the 21st Century

SUPPORTING COMMUNITIES AND LOCAL PUBLIC HEALTH DEPARTMENTS DURING COVID-19 AND BEYOND — A ROADMAP FOR EQUITABLE AND TRANSFORMATIVE CHANGE

Public Health Alliance™ OF SOUTHERN CALIFORNIA

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This document is one section of the Supporting Communities and Local Public Health Departments During COVID-19 and Beyond - A Roadmap for Equitable and Transformative Change report drafted by the Public Health Alliance of Southern California that includes policy, program, and resource recommendations to ensure that local public health departments are adequately prepared to support communities most vulnerable to the health and socioeconomic impacts of COVID-19 as well as future public health emergencies.

RECOMMENDATIONS

- Establish Programs and Funding to Advance a Community-Centered Public Health Workforce
- Adopt and Implement Structural Changes to Internal Policies to Retain, Support, and Promote Staff, with a Specific Focus on Communities Most Impacted by Inequities
- Establish Standing, Funded Community-Based Partnership Programs to Strengthen the Public Health System
- Increase Cross-Training for Public Health Staff to Strengthen and Support a More Nimble Workforce
- Coordinate with State and Federal Public Health Agencies and Leaders to Establish Incentives to Draw and Retain a Robust Public Health Workforce
- Establish a National Public Health Reserve Program to Rapidly Expand the Public Health Workforce During Emergencies
- Develop a Statewide Public Health Workforce Resilience Plan

OVERVIEW

As the only local agency tasked with protecting the health and wellbeing of California communities, local public health departments are on the frontlines of responding to innumerable community health concerns, from the COVID-19 pandemic and climate change impacts, to childhood asthma prevention and food safety enforcement. In order to effectively and equitably carry out the core functions of public health, local public health departments (LHDs) need a robust, nimble, community-centered workforce.

Persistent budget cuts and a high ratio of retirees to incoming public health professionals, have left the local public health system with a significant shortage of workers. Between 2008 and 2017, local and state health departments lost 20% of their workforce, a loss of over 50,000 public health workers across the country. In 2008, the Association of the Schools of Public Health estimated that there would be a shortfall of at least 250,000 public health workers, leaving the system largely understaffed for routine activities, let alone a crisis of the magnitude of COVID-19. Due to this ongoing disinvestment in state and local public health departments and their workforces, when the COVID-19 emergency struck, LHDs had to scramble to redeploy program staff indefinitely, rapidly hire temporary staff, and coordinate across counties to share specialized staff and facilities in order to respond to the emergency.

Despite staffing shortages, especially in specialized positions like public health nurses and epidemiologists, and an overall lack of staff representative of the communities most disproportionately impacted by COVID-19, LHDs worked tirelessly to meet the crisis. Local health departments leveraged existing relationships and forged new partnerships with other sectors, community-based organizations, and regional collaboratives to create a more expansive system of public health. Community-based organizations (CBOs) in particular stepped beyond their normal scopes and missions to meet the needs of their communities, including with providing access to basic needs, helping navigate government and other benefit programs and systems, and advocacy efforts. The CBO response to COVID-19 demonstrated the critical need for standing, funded CBO network across the State to address inequities and elevate community priorities.

In order to meet the current and emerging public health needs of the 21st century, including climate change inequities and injustice, California must prioritize a nimble, community-based, equity-centered public health workforce. In alignment with the Federal Health Force Act, meeting this goal will require policy action and programmatic changes at the state and local level.

CHALLENGES

1. The COVID-19 emergency exacerbated existing chronic staffing shortages
2. Staff often do not reflect communities most burdened by inequities and disproportionate health impacts
3. Lack of specialized staff, including epidemiologists, public health nurses, and health equity experts
4. Diversion of staff from other critical public health programs that provide support to vulnerable populations
5. Local health departments are frequently in crisis response mode, therefore many departments are unable to prioritize health equity, the social determinants of health, and structural racism

1. The COVID-19 emergency exacerbated existing chronic staffing shortages

The COVID-19 emergency exacerbated decades-long staffing shortages in LHDs, with nearly 60% of LHDs reporting that staffing was insufficient to respond to the needs of communities most impacted by the emergency. Many LHDs reported they were unable to meet the needs of their communities prior to the COVID-19 emergency and have been continuously operating from a deficit throughout the response. While CARES and ELC funding enabled rapid hiring of many temporary staff, LHDs will return to a state of chronic understaffing without an infusion of sustained non-categorical funding. Despite nearly half (47%) of October 2020 – January 2021 survey respondents indicating that internal human resources (HR) policies did not facilitate an effective COVID-19 response in terms of rapid hiring, several LHD representatives described significant improvements over time, with one stating that "it was very difficult early on, but there were some changes in HR policies and practices during the middle of COVID that helped expedite hiring" (LHD respondent).

"We do not have enough staffing to support COVID nor the other emergencies we are facing such as the equity crisis, fires, public safety power shutoffs, extreme weather, economic stress, and the mental health crisis" *LHD respondent*

Best Practices

RAPID HIRING

In order to meet the urgent need for staff to support the COVID-19 response, LHDs worked quickly to rapidly hire and on-board staff, including case investigators, contact tracers, nurses, and others. Department managers worked with internal human resources and hiring departments or private temporary employee services to increase staff numbers and department capacity as quickly as possible. For example, the Shasta County Health and Human Services Agency hired over 80 temporary staff to support COVID-19 response activities, while the Riverside Health System hired 360 new employees in 7 weeks. Some LHDs described strategies to increase the diversity of hired staff, by working closely with hiring managers to prioritize hiring multicultural and multilingual staff reflective of the communities most impacted by COVID-19.

COMMUNITY HEALTH WORKERS & PROMOTORES

Local public health departments, in partnership with community-based organizations, drew upon and facilitated the expansion of networks of Community Health Workers (CHWs) and "Promotores" (community health workers working in Spanish-speaking communities) to increase outreach to and support for impacted communities. Including Promotores and **CHWs in public health and healthcare systems** has been shown to reduce healthcare costs and **improve health outcomes** for individuals and communities with chronic health conditions. Promotores and CHWs are trusted members of the community, often with shared lived experience to the individuals whom they are serving. Given the history of racism in healthcare and government systems, as well as the fear, stigmatization, and marginalization many communities have experienced throughout the COVID-19 emergency, employing Promotores and CHWs has proved to be a vitally important strategy. As a component of the **Fresno Equity Project**, Fresno County Public Health partnered with over 20 CBOs and California State University, Fresno to launch a CHW effort specific to the COVID-19 response. The LHD contracted with CBOs to hire and train CHWs, who are paid a living wage and provided training in skills that can be applied beyond the COVID-19 pandemic.

87%

of LHD respondents said knowledge of community engagement and partnerships was the most critical staff skill in the COVID response

2. Staff often do not reflect communities most burdened by inequities and disproportionate health impacts

Many LHD directors reported that in addition to insufficient staff overall, there were very few, if any, staff that were from the most impacted communities or from a similar racial/ethnic or cultural background. Local public health department directors and managers described lack of multicultural and multilingual staff as a significant barrier in rapid response efforts, including with: developing and translating informational materials; outreach to new community-based partners from impacted communities; and building trust between communities and the LHD. One LHD representative shared that there was "no targeted outreach to impacted communities to ensure hiring from these communities." Another described an important partnership to try and meet this need: "… We would not have been able to quickly develop a culturally competent workforce, so we contracted with the FQHC [Federally Qualified Health Center] in the most vulnerable areas of the county to do outreach, education, testing…" While many LHDs made a concerted effort to hire contact tracers from impacted communities early on, as described above, those efforts could not take the place of a diverse community-based permanent staff or long-standing partnerships with CBOs.

"Our workforce looks nothing like the most vulnerable people we serve" LHD respondent

Best Practices

FARMWORKER RESOURCE CENTERS

The Ventura County Human Services Agency established the **Farmworker Resource Program** in 2019 for the express purpose of building trusting relationships among the agricultural community, connecting community members to resources, and navigating workplace issues. The program team includes multiple staff who speak Spanish and Mixteco, and are experts in farmworker issues. The Farmworker Resource Program has been a critical partner in responding to the COVID-19 emergency, which has disproportionately impacted Latinx and Indigenous communities as well as agricultural workers. While many LHDs struggled to find adequate translation services and community partners in the agriculture sector, the Farmworker Resource Program enabled Ventura County to rapidly translate **COVID-19 educational materials**, conduct outreach to farmworker communities, share information on testing and basic needs resources, and elevate community priorities during the response. In fact, this model has been so impactful that legislation has been introduced to expand this model across the State. **AB 941 (2021)** requires the Department of Community Services and Development to establish a grant program for counties to establish farmworker resource centers, which would provide information and access to essential services such as health, housing, and worker rights. The program stipulates the following eligibility criteria:

- The county entity must work with community-based organizations to develop the center
- Provide 25% of the center's program funding
- Provide service in at least English and Spanish

COMMUNITY ORGANIZERS IN LHDS

Well before the COVID-19 emergency, the Shasta County Community Action Agency established several community organizer staff positions, supported through public health realignment funds. The Community Organizers are tasked with working directly with community members, formal and informal leaders, and CBOs, to identify community assets, needs, and priorities to advance policy, systems, and environmental changes. In order to reduce barriers to employment, the positions do not have educational requirements and give preference to applicants who are bicultural or bilingual, are from impacted communities, or have worked with marginalized communities. Shasta Public Health Services leadership described these staff and their role as a trusted partner and advocate as one of the County's greatest assets in responding to the COVID-19 emergency, and noted Shasta Public Health Services' ongoing commitment to hire more staff from impacted communities.

"Hiring of any kind of technical position is very challenging. We are trying to hire public health nurses and getting no applications..." LHD respondent

3. Lack of specialized staff, including epidemiologists, public health nurses, communicable disease specialists, and health equity experts

Many LHDs, especially those in smaller and more rural jurisdictions, described lack of specialized or technical professionals as a major hurdle in the COVID-19 response. LHD representatives most frequently described insufficient numbers of public health nurses, epidemiologists, and communicable disease experts, as well as staff specially trained in health equity. Smaller jurisdictions described difficulty hiring and retaining specialized staff due to the part-time nature of many of these positions and lengthy application and hiring timelines, with one LHD Director stating, "…many times they [nurses] get hired elsewhere before they make it through the hiring process." Even larger, more well-resourced jurisdictions noted challenges competing with or matching salaries provided by the private sector or large healthcare providers. This acute shortage during the COVID-19 emergency is merely a snapshot of a larger trend: 25% of public health nurses reached retirement age in 2016, and over one million American nurses are expected to retire in the next 10 to 15 years.

4. Diversion of staff from other critical public health programs that provide support to vulnerable populations

The diversion of LHD staff to COVID-19 response activities significantly impacted provision of other services and core programs. On average, LHD survey respondents indicated that anywhere from 50-70% of their staff were diverted to the COVID response, while some shared that 100% of public health staff were diverted during the surges. Over 80% of survey respondents stated that diversion of staff resulted in gaps in critical department functions and programs, and impacted their ability to conduct community outreach and engagement. Additionally, 60% of survey respondents stated that diversion of staff caused administrative delays impacting service delivery for impacted communities. While LHDs have worked tirelessly to respond to the impacts of COVID, particularly in low-income and communities of color, the diversion of already limited staff from public health, social services, and other community-serving agencies will likely have significant adverse outcomes later on. Local public health department staff described lack of home visiting services and programs in schools as major concerns for maintaining the health and wellbeing of communities. Despite the significant challenges posed by staff diversion to the COVID-19 response, some LHD representatives shared silver linings. One LHD manager described that throughout the response effort, some line staff have emerged a major assets and future leaders in the department.

82%

of survey respondents stated that diversion of staff resulted in gaps in critical department functions and programs

"We have been able to pull staff over from existing programs, but those programs are often equally or more important than COVID response have suffered tremendously. COVID response should not trump other important work in vulnerable communities" LHD respondent

5. Local public health departments are frequently in crisis response mode, therefore many departments are unable to prioritize health equity and the social determinants of health

The decades-long disinvestment in public health departments and their and workforces, and the limiting nature of categorical funding (see "Bolster Resources and Investments in Public Health Infrastructure") undermines LHDs' ability to prioritize ongoing structural and social determinants of health work in partnership with impacted communities. Furthermore, lack of resources and staff can limit emergency prevention and preparedness activities, requiring LHDs to rapidly shift to crisis response mode in the event of an emergency. As the frequency of emergencies increases, from climate change-related wildfires and Public Safety Power Shutoffs to infectious diseases outbreaks, LHDs are required to pivot from emergency to emergency while maintaining categorically funded programs. This pattern leaves little capacity to advance the broad and deeply collaborative policy, systems, and environmental changes needed to promote health equity and social justice. The COVID-19 emergency has laid bare the glaring social, economic, and health inequities across the State and taxed California's public health system, and yet local governments and LHDs have demonstrated their continued commitment to health equity throughout the response.

Best Practices

Local governments, in partnership with LHDs and other sectors, passed critically important policies and programs to help protect and support communities disproportionately impacted by COVID-19. Policy areas addressed include housing, economics, education, and access to services. See examples below.

- Los Angeles County established **Medical Sheltering** sites for those experiencing homelessness or those unable to safely or effectively quarantine or isolate at home.
- **Santa Barbara County** issued a health order requiring daily temperature checks and health screenings in employer provided housing for H-2A status temporary agricultural workers, to mitigate the spread of COVID-19 among migrant workers.
- The City and County of San Francisco enacted an **eviction moratorium**, prohibiting residential evictions and providing 6 months for renters to repay accumulated rent.
- The City of Oakland expanded protections and benefits under the **Emergency Paid Sick Leave Ordinance** to improve access and increase pay rates.

For more examples see the California Department of Public Health's **COVID-19 Health Equity Playbook for Communities**.

"We have been successful in recent years working with advocates for policy change that impacts vulnerable populations. However, [we are] significantly behind other areas of the state in policies that reduce health inequities. This has significantly impacted COVID outcomes for vulnerable populations in the Valley – specifically as it pertains to crowded housing, ag workers, the undocumented, and worker protections" LHD respondent

RECOMMENDATIONS

In order to meet growing public health needs, local, state, and federal entities must invest in a robust public health workforce that promotes community priorities and advances health equity. The COVID-19 emergency devastated--and continues to leave long-term impacts on--families and communities, especially those already experiencing inequities prior to the pandemic. As such, it is critical for public health leaders and elected officials to seize this moment to invest in California's community and public health infrastructure. Young people and students have felt the call to action: the Association of Schools and Programs of Public Health tracked a 20% increase in applications to master's in public health programs. It is the responsibility of local, state, and federal public health entities to meet this motivation with policy and process changes to support a prepared, diverse, and resilient public health workforce. The Federal Health Force Act (2021), introduced in 2021, would have established a grant program through the Centers for Disease Control and Prevention (CDC) for States, localities, territories, and Tribal entities to "recruit, train, and employ a standing workforce of Americans to respond to the COVID-19 pandemic in their communities, provide capacity for ongoing and future public health needs, and build new skills for new workers to enter the public health workforce." In order to fully realize this change, local and state public health departments must commit to hiring people representative of impacted communities and developing funded standing partnerships with CBOs. Below are recommendations to advance these goals.

Establish programs and funding to advance a community-centered public health workforce

The California Future Health Workforce Commission identified the expansion of "pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers" as the number one priority in their 2019 assessment of California's health workforce needs. The COVID-19 emergency underscores the need to ensure the LHD workforce is reflective of the communities they serve and prioritizes hiring people from these communities. It is important that LHDs adopt and implement the following practices to increase diverse local hiring practices.

- Implement standard policies to prioritize hiring staff, at all levels, who are from the communities served, and decrease barriers to enter the public health workforce. Policies can include the following;

  - » Changing and/or removing language requirements and formal education minimums
  - » Prioritizing lived experience and community knowledge
  - » Removing questions related to criminal background and documentation status
  - » Removing Driver's License requirements
- Partner with CBOs, high schools and community colleges, re-entry programs, social services, and other workforce development programs to establish paid public health internship and mentorship programs, and career pathways
- Collaborate with diverse stakeholders to develop and establish a Public Health Corps program and funding stream to support young people, people from local communities, and people from communities most impacted by inequities to enter LHDs

- Expand the role of CHWs and Promotores to more actively include these critical workers in decision-making, organizing and civic engagement
- Develop and provide certification programs for CHWs and Promotores, people to assist in navigating various benefits and systems programs, home visitation workers, and others to increase acquisition of employable skills
- Establish community organizers as standard positions in LHDs

Adopt and implement structural changes to internal policies to retain, support, and promote staff, with a specific focus on communities most impacted by inequities

Complementary to the hiring recommendations outlined above, it is important for LHDs to implement changes in internal policies and processes to retain and support staff, especially staff of color, and staff from communities impacted by inequities and other marginalized communities. Local public health departments can implement policies to cultivate a culture of equity, transparency, and accountability, including: salary transparency and equity policies to mitigate pervasive gender and race/ethnicity wage gaps; and policies that provide clear and supportive mechanisms to report and address discrimination and harassment. It is critical that LHDs adopt transparent promotional practices and prioritize promoting staff of color and from impacted communities to management and leadership positions. The Local and Regional Government Alliance on Race and Equity has developed many resources to help local government agencies institutionalize racial equity, including Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas into Action.

Establish standing, funded community-based partnership programs to strengthen the public health system

A truly equity-centered, community-based public health system requires two critical elements: a diverse community-based workforce (as described above), and long-term, funded partnerships with a network of CBOs that are coordinated with local public health departments. In order for the public health system to authentically identify, uplift, and address community priorities and advance health equity, communities must be represented within the LHD and be well-resourced to engage with and hold the department accountable. Throughout the COVID-19 pandemic, LHDs with longstanding, trusting partnerships with CBOs have been better positioned to equitably respond to the needs of disproportionately impacted communities in a rapidly shifting environment. Community-based organizations, often with little or no financial support, have expanded their scope and stepped into entirely new roles to protect and support their communities; they are a central pillar of the 21st public health system and must be resourced as such.

Local public health departments, and local government more broadly, need to provide on-going funding, not merely project or activity-specific, to a CBO partner network to facilitate continuous partnership and power-sharing in decision-making, policy and program development, and emergency preparedness and response.

Increase cross-training for public health staff to strengthen and support a more nimble workforce

Throughout the COVID-19 emergency, LHD staff have had to adapt to an everchanging landscape and often step into new and unfamiliar roles. However, this necessary flexibility is not unique to responding to this crisis; increasing opportunities for staff to acquire new skills and participate in training in new topic areas will be helpful in standard public health functions and future emergencies. All staff should be trained in foundational equity principles, including implicit bias training, use of equity tools in decision-making, as well as strategies for building authentic, trusted, community-based partnerships. Additionally, staff should have opportunities to develop skills related to culturally-competent messaging, and understanding and communicating data. The COVID-19 pandemic has also underscored the importance of interagency collaboration and coordination in facilitating an all-County or all-government response. Creating opportunities for public health staff to learn about roles, capabilities, and dynamics of other agencies will enable increasingly effective partnerships to address emergencies and ongoing cross-sector issues, such as housing, transportation, land use, and climate change.

See the California Chronic Disease Prevention Leadership Project's Public Health Workforce Imperative for more information and recommendations.

Coordinate with State and Federal public health agencies and leaders to establish incentives to draw and retain a robust public health workforce

In conjunction with internal policy and practices changes, it is important that LHDs coordinate with the California Department of Public Health (CDPH), other state level agencies and partners, the US Department of Health and Human Services (HHS), and other Federal agencies and leaders to implement structural changes to increase the State's public health workforce. As a component of the Public Health Workforce Resilience Plan (described below), it is important the US HHS and CDPH conduct an assessment of salary ranges across the private and public sectors, as well as cost of living fluctuations and variations to ensure LHDs are able to offer competitive salaries, particularly for highly-trained specialized positions. Additionally, local and state agencies can explore and advocate for more robust loan forgiveness programs for public health professionals at the state and federal level, reducing

the financial burden of higher education, especially for low-income and communities of color.

Establish a national public health reserve program to rapidly expand the public health workforce during emergencies

Lack of specialized staff within LHDs has been a significant challenge throughout the COVID-19 emergency. In order to increase public health preparedness for the next emergency, CDPH and the California Department of Health and Human Services can collaborate with the US HHS and other state health departments to establish a National Public Health Reserve Program. A Public Health Reserve Program could be modeled off of the Medical Reserve Corps, and could include retired public health professionals (e.g., public health nurses, epidemiologists, etc.) as well as public health professionals working outside of the government public health system. In alignment with the Federal Health Force Act, creating a national program would enable mutual public health aid across states to respond to local and regional emergencies, while increasing the resilience of the country's public health system as a whole.

Develop a statewide public health workforce resilience plan

In order to effectively and equitably, plan, fund, and implement the above recommendations, it is important for California to develop a statewide public health workforce resilience plan in alignment with the Public Health Infrastructure Resilience Plan (see Resources & Investment chapter). Recent legislation, AB 240 (2021), laid the foundation for this plan by proposing to create a LHD workforce needs assessment, including recommendations for future staffing, workforce needs, and resources. If this bill or a future iteration moves forward, it is critical that the development of the needs assessment and the workforce resilience plan includes community representatives throughout the process to ensure that community priorities are elevated throughout, with particular attention to the development of a community-based workforce pipeline and strengthening the CBO network as a pillar of the State's more expansive public health system.