Aligning Public Health Workforce Competencies with Population Health Improvement Goals

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The Affordable Care Act (ACA) includes goals for improving the health of the entire U.S. population. The skills of the workforce directly involved with the delivery of patient care and population-based programs to improve health must in turn be sufficient to match those goals. However, over many decades, reports continue to document deficits in the competencies of the health workforce and particularly in public health professionals. This should fuel a sense of urgency to strengthen the structures for educating and training the public health workforce if we are to achieve desired ACA population health improvement goals.

Since the passage of the ACA in March 2010, several efforts to draw national attention to needed improvements in the education and training of the public health workforce have been conducted. In November 2010, the Department of Health and Human Services Office of the Assistant Secretary of Health released the report “Priority Areas for Improvement of Quality in the Public Health System” (Priorities Report). In part, a major reason for identifying priorities for improvement was to strengthen foundations for quality in public health practice. This was viewed as imperative given the ACA’s emphasis on quality as a catalyst for improving the health of the nation. The Priorities Report specifically included public health workforce and education as one of six areas urgently needing improvement in quality. Criteria used to select public health workforce and education were the impact that such improvements would have on the health system, the improvability of processes and health outcomes that could accrue through improvements in workforce quality, and the wide degree of practice variability where gaps existed between current versus evidence-based practices that, if closed, could strengthen the system to improve health outcomes.

The Priorities Report called on institutions, educational as well as employer, to ensure workforce professional competence and noted that many workers were in public health jobs where critical educational content was not available to meet needed competencies. Highlighted in the report was the observation that the lack of alignment between needed competencies and educational content hindered a worker’s ability to align job expectations with personal educational goals. Such obstacles to appropriate levels of education negatively impact recommendations made for encouraging and valuing lifelong learning.

Support for more public health educational offerings by the nation’s community college system was noted as a means to recruit a more diverse mix of students to public health careers, as was increasing the pool of educational institutions available to currently employed public health workers who do not hold a degree, and increasing continuous educational opportunities for lifelong learning. This is significant, as the report also noted that in one state roughly 60% of state and local governmental public health workers lacked a degree.

Attention was also drawn to the fact that fundamental finance and business management course content applied to public health settings was not available in Master of Public Health (MPH) programs or, when available, was not widely offered beyond policy and management tracks. The significance is that future leaders in other public health disciplines (e.g., biostatistics, epidemiology, behavioral health, environmental health) probably graduate with no exposure to financial and business management concepts even though they may eventually advance to hold high-ranking positions requiring these skills (e.g., department head, agency director). Ironically, although quality is a catalyst in the ACA for stimulating population health improvements, a recent informal survey found that educational content on quality is not available in most MPH programs, and when available, it is concentrated primarily on quality in medical care settings.

More recently, CDC developed a National Public Health Workforce Strategic Roadmap as a tool to frame discussions at the 2012 Public Health Workforce Summit. The roadmap included goals and related strategies to document the critical needs to strengthen the health workforce in order to contribute to population health improvements. Major themes in the roadmap also called for strengthening all levels of the educational system while improving the capabilities of the workforce. A selection of roadmap strategies that also echoed themes...
from the Priorities Report included defining and aligning needed skills and competencies, expanding programs that promote public health careers early in a student’s educational experience, promoting a culture for workforce professional development, and enhancing interprofessional teams and education.

The WHO defines interprofessional education as an action that “occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.” Interprofessional has also been offered as a descriptor for transforming education and practices in the system by eliminating barriers between health care and public health. Folding public health principles into the education of clinicians is a necessary step for that to be accomplished.

This is particularly relevant for achieving improvements in population health where a coordinated approach can best advance desired health outcomes. For example, in 2010 Rust et al. showed that between 1950 and 2000, better health outcomes were achieved in seven of the ten leading causes of death when a disease (e.g., HIV/AIDS, stroke, heart disease, tuberculosis) was targeted with both a public health and medical intervention. In spite of knowledge about the power of interprofessional education, it was noted by Harrison Spencer during an IOM workshop on interprofessional education that “public health and its framework for population health have not been integrated into interprofessional education.”

Building public health into these education models also means that public health professionals must be able to collaborate and communicate effectively with a broad range of other professionals. This is critical especially when working in teams. They must have comparable levels of knowledge and competencies. The following example is offered to illustrate the importance of this.

The ACA serves as a catalyst for quality improvement to achieve better health outcomes. The quality movement actually grew out of a desire to improve products and services by reducing cost. Disciplines such as health care have built education and training courses in both quality and finance in addition to implementing practices and research to examine for the financial benefits of quality. By contrast, public health degree programs still are not widely offering educational content on either topic, and workplace practices and research are equally as sparse. This renders the public health professional ill equipped to collaborate on related topics. The momentum for interprofessional education and practices is moving forward. Employers are acknowledging that there is in fact a drive toward interrelated goals between public health and health care. They also acknowledge that many fields can and must benefit from public health skills. The public health profession must ensure that educational and practice opportunities equip this workforce with the desired skills and competencies to contribute to achieving desired goals for improvements in the health of the population.

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