
SCHOOL OF PUBLIC HEALTH
The UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

*The NORTH CAROLINA
Institute for Public Health*

***Central Partnership for Public Health
Workforce Project***

***Staff Focus Groups
Summary***

May 26, 2006



North Carolina Institute for Public Health

Central North Carolina Public Health Partnership Workforce Project

Staff Focus Groups Summary

Methodology

The Central North Carolina Public Health Partnership, a collaborative of nine local public health departments, requested assistance from The North Carolina Institute for Public Health (NCIPH) in gathering information from the staff of their agencies to support an ongoing study of issues affecting retention and recruitment in the regional public health workforce.

The Partnership and NCIPH worked together to develop (1) a focus group protocol and (2) a survey methodology to gather the opinions of staff regarding issues that affect workforce retention and recruitment. This report summarizes the focus group component of the project; the staff survey component will be described – at both regional and local levels – in subsequent reports.

The NCIPH provided the site, facilitator and note taker in conducting a total of four focus groups: two groups comprised of employees identified by their Health Directors as “high achievers”, one group comprised of employees considered familiar with issues of “health disparities and diversity”, and one group comprised of employees who work with or serve members of the Latino community. Among the nine participating health departments, three (Durham, Guilford and Wake Counties) were asked to recruit two members to attend each of the four sessions. The remaining six health departments were asked to recruit one member to attend each session. Thus a total of 48 employees were invited to attend the focus groups; 44 ultimately participated. Two groups were held on Tuesday, April 25th, and two more on Friday, April 28th; each group lasted approximately two hours. With the permission of the participants, each session was tape recorded, not for transcription but as back-up for the note taker.

A copy of the focus group discussion guide is appended to this report.

Results

The following sections summarize the comments of the participants in the order in which the discussion guide topics were presented. Because the focus group members agreed to participate on the condition of confidentiality, every effort has been made to eliminate references to specific people, places or agencies in describing and quoting the participants’ responses. For purposes of clarity it has been necessary to retain some professional identifiers, such as “nurse.”

Q: What attracted you to public health?

Participants could be grouped in three primary categories according to their path to a career in public health: (1) those who started in other fields or sectors and were attracted to public health

for specific reasons; (2) those who discovered an early interest in public health and actively pursued a career in it; and (3) those who happened upon the position in public health and discovered that the work suited them. The primary fields or sectors from which participants came to public health included criminal justice, hospitals and nursing homes, non-profit organizations, social services, and mental health.

Most of the nurses who participated in the focus groups reported at least some exposure to public health while on a rotation in nursing school. Some of them “*fell in love with public health*” then and so began their nursing careers in public health. Others recalled actively disliking that rotation and coming to public health after working first in the private sector.

Many of the participants said that one of the most appealing aspects of public health is its orientation to the public. They like getting to work with people who are typically underserved, feeling like they can make a difference in people’s lives, meeting a need that would otherwise be ignored, establishing relationships in the community, and helping to educate people about their health needs.

Many participants, and especially nurses, were attracted to the “*regular hours*” (i.e., no required weekend, holiday or third shift work) and generally “*decent*” vacation time possible with a public health position. Most participants concurred that the flexibility they were allowed to make their own schedules was especially attractive, particularly for women with children.

Other desirable aspects of working in public health cited by participants included:

- A steady salary and good benefits (although these vary from county to county).
- A sense of autonomy: getting to make one’s own decisions, determine one’s own hours.
- Less stress and personal impact than in the private sector [especially for nurses].
- A variety of work to match the skills, interests, education, personality and preferences of an individual (e.g., being able to apply a skill or preferences in working with children or alternatively a wide range of clients, working outside (not in a desk job), always being busy, being able to work on many different projects, or in a number of different settings, etc.).
- Being on the prevention side of health, as opposed to the treatment end.
- A broader focus than many non-profit organizations.

Even as the participants identified what was attractive about public health they admitted that the private sector was “*wising up*” to these elements and had started to offer similar things: more flexible work schedules, more opportunities for advancement, less paperwork in a more computerized setting, and higher pay and signing bonuses.

Q: What attracted you to your current local health department?

Q: What keeps you with your local health department?

Many participants reported having been attracted to a local health department for many of the same reasons they were drawn to public health in the first place: a steady salary with good benefits, flexible and regular hours, no weekend, holiday or third shift work, getting to help people who don’t have other options, utilizing talents and strengths, and making a difference.

Almost all of the participants maintained that they are passionate about the work they do; indeed that they *must* love what they do because there are a number of more lucrative circumstances under which they could be working:

I love what I do. . . . I took a substantial pay cut for this job, but the quality of work I can do, the relationships I have, are great.

Some of the participants said that they applied for a position in the health department simply because it was open or because they needed a job. A few were actively recruited for their current position in their agency. Several participants had connections in the health department and “*networked*” their way into a job.

Many participants reported they were drawn to the location of the health department. Some had grown up in the same geographic area and felt particularly connected to the local community or liked the idea of serving the local community; others said the health department was “*more convenient*” than other options.

The participants had a wide range of reasons for remaining with their current health departments, but for most, the “*feel-good*” aspect of the work was a major incentive to stay. Simply put, they like working for and with clients who really need what they can offer.

Some participants report a loyalty to their agency because of the quality of the services it offers. Several participants concurred in the belief that the primary care clients receive in their agency is comparable to, if not even better than, health care in the private sector.

A positive working environment was cited by some participants as an incentive for them to remain with their agency. Supportive and flexible supervisors, a supportive health director, the family nature of the organization, leadership that cares about and understands the “*underlings*”, and caring and friendly colleagues were identified by participants as workplace qualities they experienced and appreciated.

A large number of participants remain with their current health departments for primarily practical or personal reasons: good health insurance and retirement benefits, flexible and regular hours, short commutes, and being able to drive a county car.

I’m waiting out [until] retirement.

If I didn’t have comp time, I wouldn’t be there.

Holidays, vacations, [and] time-off are better than I can find at the same job level in the private sector.

We’re seeing more 40 [years old] -plus applicants because they’re thinking about longevity, and stability, and retirement. And these are the nurses who will stay.

And in response to that statement:

Older nurses have to stay. We can’t handle private sector nursing; it’s too stressful.

Participants also mentioned the following aspects of working in a health department as reasons for staying:

- The people and the community that the department serves
- High quality colleagues
- The variety of services offered
- Serving as an advocate for clients
- The work is never boring
- Support for education and training
- A sense of autonomy
- The fact that a position is not funded by a grant

A surprising number of participants weren't even aware of what a local health department did when they applied for a position, a characteristic all participants now recognize as common among the general public. All the participants were aware of – and seemed frustrated by – the many misconceptions the general public has about the health department: that the health department is where you go only if you have an STD or need a shot; that it only serves poor people and drug users; that everything the health department offers is free; that the facility is always in a bad part of town. There was sweeping consensus that something needs to be done to address the public's perception of the health department in order to make potential clients and employees more aware and informed.

Q: What expectations did you have about the job you took or the work you thought you'd be doing?

The general consensus in all the groups was that, regardless of how they started with the agency, their roles had evolved and changed over time, usually to involve more duties. Some participants reported that their work shifted in a more “*lateral*” direction.

One participant reported not having seen a job description at the time of hire, and went on to say that if an accurate description of the current job duties had been available then, “*I might have turned down the job.*”

Some of the participants who had spent the majority of their careers in public health felt that “*what we're doing now is very different than what we were doing when I started*”, because health problems and client populations have changed.

There also was a strong sense among participants that public health has moved toward a more business-like model of service delivery, which many of them – especially those not in administrative roles – regard as a negative trend. While many participants understand that competition for funding and clients is forcing public health to function as a health care business, they nevertheless resent the pressure they are under to see more clients, to quantify work that is not quantifiable, and to meet quotas:

The private sector is always about the money; that's part of the reason I left the private sector.

Several participants said the variety that was once an appealing part of their work has disappeared. Nurse participants explained that they used to work in clinics, do home visits, act as school nurses, and serve pediatric and adult clients, and many found that to be exciting and enjoyable. Now, however, some feel limited to one area of the health department, or to one age group.

Interpreters particularly reported that they were unaware of how broadly they would be used in the agency when they took the position. According to them, health departments either hire interpreters, who float throughout the agency working with anyone who needs translation for whatever reason, or (especially in the larger agencies) hire bilingual staff members to work in specific positions serving the non-English speaking community. The frustrations were similar for both categories of Spanish-speaking staff, because *“as soon as it’s known that you’re bilingual, you get used wherever they need you”*. Interpreters reported feeling *“stretched thin”* and pulled in too many directions. They end up saying everything twice: repeating an English question in Spanish for the client, and then repeating the client’s Spanish answer in English to the staff member. Several interpreters thought that efficiency would improve if they were trained to actually care for clients themselves. Bilingual staff reported that they felt that their language skills were taken advantage of, often to the point that the jobs they were originally hired to do suffered because they spent so much time translating for other staff members.

Q: What are some challenges to your job?

Public Stigma

There was wide agreement in all four focus groups that health departments still carry a great stigma as regarded by the general public. The participants feel there are many public misconceptions about what a health department is for, what services it offers and why, the breadth of the population it serves, how much services cost, where it is located, and who works there. They believe the stigma not only keeps potential new clients away, but it falsely labels agency employees as *“not good enough to get a job in the private sector”* and does nothing to attract new employees to the health department or to public health in general. One participant suggested that the public won’t appreciate the health department until it really needs the health department, and that avian influenza might be the event that will make people see how necessary the health department is. Many participants recommended a public relations or advertising campaign to raise public awareness and bolster the image of the local health departments: *“Send the message that we’re vital”*. Some thought that the state of North Carolina should fund the effort, but acknowledged that all health departments differ in what services they offer and so the message would need to be tailored specifically for each county.

Lack of Opportunity for Advancement and Reward

There was almost unanimous agreement in all focus groups that there is little opportunity for advancement in local public health departments. Participants described the lack of a career track as frustrating for current employees and a distinct disincentive for potential new employees. Participants in supervisory roles expressed disappointment that there was *“no way to reward staff for excellent behavior or performance.”*

Funding

Participants described a number of challenges that related to funding, among them cuts in Federal block grants, diminishing CDC funding, and having to support their own salaries with fee-based programs. One participant stated the issue concisely: “*Budget cuts at all levels get passed down.*”

Changing Population and Client Base

Some participants acknowledged that, given the current number of employees in their health departments, the sheer size of the population which the agency serves can sometimes seem overwhelming. The catchment population for the health departments has been increasing while the number of staff to serve those people hasn't grown as quickly, if at all. This challenge seems to be felt especially among the participants who work with the Hispanic/Latino population, which heavily utilizes health department services.

Intra-Agency Tensions

It became apparent during discussion that there are underlying tensions between some groups of employees within the health departments. Some of the friction may be the result of perceived – or real – issues of territorialism, favoritism, and pay scale inequities. According to participants, internal tensions can arise or be exacerbated because of miscommunication, or simply because units are housed in different locations. But regardless of whether the conflict is a question of actual inequities that are inherent in the system, or whether it grows out of false impressions, the tension is felt in a very real way and a significant number of participants felt that their daily work lives were impacted.

According some participants, agency employees have a tendency to competitively evaluate workloads, time spent, and money earned. They explained that employees in one section or unit of the agency may think they contribute more than employees in another. They offered the following examples:

- Environmental health workers work mostly in the field, so since their work is largely unseen by most staff it is easy for others to judge their contribution as minimal.
- Because some categories of employees (e.g. nurses) are paid more than others (e.g. social workers), it can appear to send a message that, for example, nurses are more valuable than social workers.
- Clinics generate more money than health educators, so health educators fear getting cut.

Such perceptions of other employees and units are often inaccurate, perhaps because communication is hampered by the spread-out nature of many health departments. There can be a sense that people in the “main” facilities have better opportunities, just because they're housed in the same building as the administration.

Environmental Health vs. Everybody

The participants who represented environmental health said they often feel like the “*red-headed stepchild because we don't save babies*”. The Environmental Health Division of many health

departments is often located in a different facility than the rest of the agency, which made some of those participants feel isolated and unimportant; others among them preferred being housed separately. One participant expressed particular frustration that very few people, in the general public, within county government, or even in the health department, understand that environmental health workers are protecting the health of the public every bit as fervently as the rest of the health department.

Social Workers vs. Nurses

From participant comments it would appear that there are particular tensions between social workers and clinical nurses. Some social workers (and some health educators as well) say they have noted inequities in support and rewards for additional training and education: nurses in some agencies get automatic raises when they go back to school, but the same is not true for social workers in those agencies. Social workers also report that nurses are allowed flexibility in hours and compensatory time that is not afforded to other employees within their agencies. According to social workers, some nurses still don't know exactly what public health social workers do or how beneficial they can be. Part of the problem may be traceable to generational differences. Career nurses who have worked in public health for many years began their careers serving as counselors and educators as well as nurses. Some of those career nurses may not know where to draw the line now that other staff has been hired to address client counseling and education. Both nurse and social worker participants reported occasionally feeling that the other party is doing something they either aren't qualified for, or shouldn't be doing at all.

Generational Differences

In all focus groups, there was a sense that older and younger generations of employees do not always see eye-to-eye. Participants who had worked in public health for many years stated that younger employees didn't seem to have a positive work ethic, or "*strong internal reasons for wanting to do a good job*". According to older participants, in the "*good old days*" of public health there was a familial nature to the work and people were more willing to pitch in to help colleagues. They feel that among the younger employees that sense of loyalty and connection has been replaced by resentment for the work and the colleagues. One participant countered that, "*harping on the good old days that cannot be regained*" turns off newcomers to the field.

Participants in another group suggested that younger employees can find the environment too controlled, and resent the accountability they're held to. For instance, having a job that involves field work leads some young employees to feel that they can use some of that "field time" for personal pleasure, but then they get angry when a supervisor dares to check up on them. There seemed to be a general consensus among participants that younger employees use the health department as a stepping stone and move on as soon as a better offer comes along.

Management vs. Staff

According to several participants in different focus groups, conflict exists between management-level employees and front-line staff, and in their belief some of this tension has to do with the generational gap. Participants explained that "seasoned" supervisors can get stuck in the way they do things and are perceived as resistant to change and new ideas. One participant suggested that staff may not discuss new ideas or address troublesome issues with management for fear of retaliation; some younger employees have reportedly left agencies because of this. Several participants suggested that supervisory roles are very hard for front-

line staff to achieve, as the positions are often filled internally, before the jobs are even posted, and often by individuals who are well-connected as opposed to well-qualified.

Organizational Change

Consolidation, collaboration and change can be challenging to employees in local public health departments. Some participants complained that organizational change in their agencies had been poorly managed, especially from the standpoint of communication, which they felt was inadequate, confusing, and in some cases inappropriate. According to some participants, organizational change may be communicated properly but then plagued by the results of poor planning or inadequate follow-up, leaving staff unsure of what to do, or feeling poorly or unfairly treated.

Intra-agency collaboration in some agencies apparently has not always been comfortable or successful, given some of the tensions detailed in the previous paragraphs.

Multi-disciplinary stuff doesn't always work because it feels like letting go of the control.

Some participants, on the other hand, reported great success using interdisciplinary teams, in their view at least in part because they were continually motivated to focus on a goal of being as helpful as possible to the clients.

County Government

A large number of participants concurred that a dependence on county government is one of the biggest challenges of local public health agencies. Many participants characterized the Board of County Commissioners as disinterested or uninformed about public health and the populations it serves. One participant offered the following example: In that county the commissioners apparently recommended that the staff of the agency's Home Health and Hospice unit keep regular business hours; this recommendation was perceived as particularly ignorant and insensitive by the employees of the unit who were aware that people die at all hours of the day.

County government . . . doesn't understand what we [Home Health and Hospice] do, how we fit into the health department, what the health department does.

Some participants expressed the belief that county government tends to favor the most visible or measurable programs and services. For example, they said, health education programs are acknowledged to be beneficial, but do not generate money and have few deliverables to show, so is easy for county governments to consider cutting them.

Participants complained that county policy can sometimes be limiting, unnecessarily burdensome, or irrational.

You may have found a great deal on supplies, but the county makes you get three bids instead.

Several representatives from environmental health sections said they had been asked by the county government to quantify their site evaluations and were expected to meet quotas. They protested that their work was site-specific and very difficult to quantify:

There may be three holes to dig, or we may be surveying 40 acres.

Other participants, from a number of different agency units, expressed similar frustration with quota systems. Apparently many of them are expected to provide a certain number of contact hours with clients, or provide health education to a certain number of organizations, every month.

But if you do your job well, you've helped an organization or family enough that they don't need you for as many hours the next month.

Participants say they find themselves pestering the clients, asking, “Are you sure you don't need anything else?”

The Business Model

All groups concurred that staff in all their agencies are frustrated by the business model of care that public health seem to be moving toward:

We have to remember that it's prevention at the same time that the higher-ups are saying, 'Get people in your clinic so you can pay your salary'.

Participants perceive that funding seems to be directed toward primary care and that as a result agency staff are under tremendous pressure to see as many clients as possible; this, participants feel, often means that the quality of care is diminished. In addition, they noted with frustration that providing some services (like diabetes education) is much easier and less time consuming than other services (such as AIDS counseling), but that staff in both areas are expected to meet the same metrics for numbers of hours or clients. And most focus group participants acknowledged there seems to be no system in place to reward increased workloads or a particularly successful project:

We urge productivity, but don't pay for increased productivity.

Participants apparently find it particularly galling that they are faced with “the pressure of the business model with none of the rewards [overtime, bonuses, raises, advancement].

Other Challenges

- High risk areas and populations
- The politics of management
- Mental health reform, the negative effects of which were predicted by some participants to spill over into public health agencies
- A pay scale that does not reflect the skills required to do the job well (especially the need to be creative in the face of decreasing program funding)
- The recent appearance of Spanish dialects which many interpreters do not understand
- Rapid and frequent state-level program changes that are difficult to keep up with
- Unfunded state mandates
- Lack of Spanish language skills among most staff
- The volume, redundancy and complicated nature of required paperwork

Special Challenges for Minority Employees:

- “Constantly feeling like you have to prove yourself within the organization”
- Competition as to which minority population faces the worst health problems and therefore needs more money [perceived primarily as the needs of the African American population vs. the needs of the Latino/Hispanic population]
- A lack of male employees in public health (with the exception of environmental health), particularly minority males
- A lack of diversity in middle and upper levels of management, which often doesn't reflect the diversity of front-line staff

Q: How does diversity in the workplace affect your ability to serve people?

According to some participants, their agencies were actively working on increasing staff diversity because they recognize that they need to “look like” the community in order to serve the community. Other participants reported their agencies were not “*tuned into*” the diversity issues among their own staff and that they did not adequately advocate for minority populations. A few participants described agency management staff and employees who simply were unaware of diversity issues and did not realize that certain behaviors might be seen as offensive to minority staff. According to focus group notes, there is at least some belief among the participants that active racism exists in some agencies and that it prevents the proper perception of minority staff, their needs, and their achievements.

There was wide agreement among participants that clients look for diversity in the staff when they walk in the door of a health department, and that if they see the expected diversity they are likely to feel more welcome. This perception was enforced particularly by interpreters who said the fact that agency front desk staff isn't bilingual or bicultural may actually “*keep people away*”.

Participants from several agencies said that while their clinical staff is appropriately bilingual, the staff in their information center or at the front desk is not. Some participants reported having observed instances when front desk staff simply assumed that Hispanic/Latino clients did not speak English and walked away to find an interpreter before even addressing the clients, who might actually have been able to express their need. In cases such as those, clients may end up insulted and interpreters spend valuable time doing what front desk staff could do if they knew even very basic Spanish.

Participants experienced in working with minority populations acknowledged that minority clients are much more likely to open up to minority providers. White social workers, Baby Love staff, or other staff who make home visits may be perceived by their minority clients as “*nosy and looking for bad news*”. According to participants, minority clients also are especially perceptive about and offended by how white staff members behave in their homes (e.g., not sitting down on the furniture, stiff body language, etc.). Participants said African American clients will be much more comfortable and honest with an African American employee.

A number of participants agreed that minority employees are still dealing with prejudice and they tend to stifle complaints or ideas because they can easily be labeled as troublemakers. Spanish-speaking participants said they were discouraged from speaking their native language among themselves because non-Spanish speaking staff assumed they were being talked about behind their backs.

While a number of participants suggested that language classes or cultural diversity training should be made more available to – or even mandatory for – health department employees, other participants countered that there will always be resistant individuals.

As much as you encourage staff to learn Spanish, some employees will always be of the mindset that the immigrants should learn to speak English instead.

There was agreement among minority participants that the people who could benefit most from cultural diversity training are the usually the ones who don't attend. Even if diversity training is required, "you can attend the training and still not learn anything if you don't listen".

Some participants, among them representatives of minority groups, appear convinced that job applications from minority candidates may be handled differently from those of other applicants, and that the interview process may not be standardized, both in terms of the questions that are asked and the minority representation on the interview team. Some participants believe that some applications may be "thrown away" simply because the applicant has a thick accent or a foreign-sounding name.

Super-qualified and experienced people aren't getting the jobs.

One participant reported finding the lack of diversity in other agencies to be a challenge, offering the following example: a Hispanic client with HIV/AIDS needs other sorts of services, such as drug abuse treatment or job training, but the agencies that could provide those services can't handle non-English speakers. This participant felt that clients' trust can get lost when they discover they've been referred to someone who can't really help them.

Q: How can we recruit new people to public health?

Participants suggested that in order to address the recruitment of a diverse workforce it will be necessary for health directors as well as Boards of Health to really *want* to increase diversity and cultural awareness.

Make the organization culturally competent and sensitive from the top down.

Participants' most numerous recommendations for recruiting new people centered on establishing a career track and paying employees more. There was a common sense that there is room for lateral movement within the local public health department, but that upward movement is nearly impossible. A number of participants reported feeling frustrated that, "At some point you feel like you've gotten as far as you can in one position, but the pay never changes".

Participants complained that supervisors seem rarely to leave, and that in the level beneath supervisors a person who has been with the health department for years may have the same title as someone who was "hired last month". Perceived pay and policy inequities between veteran and newly hired employees at the same level trouble many participants.

You work really hard to improve yourself and only make a few thousand more than a new person with very little experience or drive.

According to participants, in some counties new employees can negotiate salary, but if a current employee moves around within the department salary negotiation is not possible.

Participants suggested that local agencies create a career track, tell people about it, and then let them move up it. They recommend that agencies encourage employees to set personal, educational and professional goals and then help them to accomplish those goals, and that they implement a rewards system to recognize improvement, success, good behavior, good performance reviews, and longevity.

Many participants felt that health departments and county governments need to face the fact that the pay scale often does not match the cost of living, particularly in the larger counties involved in this project.

It's not that they don't like the work, but there's no way they can afford to do it.

We still have a love for the work and the community. We need to be able to afford to live in the community.

Participants cautioned that if performance-based raises are given, many counties might overlook the need for a cost-of-living raise. Participants believe that those public health agencies that can offer more competitive salaries and more impressive benefits will continue to lure employees away from smaller health departments.

All groups agreed that recruitment efforts need to start at the high school level by encouraging students, particularly minorities, to go on to college. Participants said they would like to see public health included in high school civics or science curricula. Participants suggested that internship and mentoring programs might be an especially effective way to encourage young Hispanics to consider a career in public health. Several agencies apparently have had luck connecting to colleges and universities that feed the public health workforce, especially those with programs targeted toward minority students. There was considerable agreement among participants versed in language issues that it is easier to train a bilingual young person in public health than it is to teach English or Spanish to an individual experienced in public health. These participants suggested hiring Hispanic/Latinos who speak both English and Spanish very well and then give them on-the-job training in public health.

Participants in all focus groups recommended addressing what they describe as a "disconnect" between theory and practice in some traditional educational programs. They noted, for example, that social work students work with a health department for a year, while nursing students only pass through briefly. They understand that students might not like what they know about public health, but feel that what they know about public health is often wrong. For instance, participants said there is a perception that nutrition is remedial, but when interns see what the nutritionists actually do on a daily basis, they realize the field wasn't accurately represented in school. As another example, participants say students of environmental health are too narrowly prepared for the wide range of responsibilities they may have in the field. If students want to move laterally within environmental health, they ought to leave school knowing about many different things.

Participants suggested that educational institutions create curriculum tracks to prepare students for specific positions, or offer scholarship programs like NC Teach (where the state pays educational costs for students who agree to teach for four years), especially to recruit bilingual

staff. Others thought that summer internship programs would be valuable for giving potential recruits an accurate representation of the work involved. Some environmental health participants lamented the time that must be spent training new employees and recommended that universities and colleges offer some of the certifications (e.g., Registered Sanitarian certification) that are required of almost all environmental health employees.

Common to all the focus groups was the expressed need to address ambivalent or negative public perceptions of the health department in order for it to be an attractive employment destination. Many participants across all focus groups contended that public health departments provide better care than the private sector, and agreed that this point needed to be highlighted for the general public.

Other suggestions for improving recruitment included:

- Recruit on a national and international level, especially since the Internet has great tools for posting and advertising jobs.
- Work out a system that will recognize foreign degrees and certifications, or establish American equivalents for training and experience acquired in foreign countries, in order to hire bilingual staff.
- Compensate bilingual staff for their special language skill, a skill that is always utilized, even to the detriment of other job duties.
- Satisfied employees will recruit in a natural, word-of-mouth way. *“If you’re excited about your job, if it makes you happy, you’ll tell your friends.”*
- Younger employees *“like immediate gratification”, like their ideas to be welcomed”,* so give them extra responsibilities (like attending meetings), and recognize their skills and interests.

Q: How can we improve retention of current employees?

Aside from repeating some of the same suggestions regarding recruitment (namely improving the pay scale and establishing a career track), participants offered the following ideas to improve retention:

- Continue to maintain a favorable schedule: no nights, weekends, or holidays; keep flexible working hours.
- Establish a working environment that is free of drama, pettiness and unprofessional behavior.
- Don’t micromanage employees unless there’s a problem. *“Let your people do their job. That’s what you hired them for.”*
- Establish a mentoring system that matches young or new employees with more seasoned employees, minority employees with other minorities, future leaders with current leaders, and front-line staff with management.
- Hire an in-house retention specialist to serve as a link between management and front-line staff and play an on-the-job ombudsman-type role.
- Provide more educational support.
- Show more appreciation of line staff; recognize them in front of *“higher-ups”*.

Q: Any other comments or observations?

“Everyone is trying to find a way out.” It is interesting to note that almost every participant in one of the focus groups was either planning to go back to school or had already gotten an advanced degree in preparation for moving out of public health. They were taking these steps not because they wanted to, but because they intend to be ready when they are *“sent to the chopping block”*.

A number of participants were simply resigned to the fact that public health was always going to be a transitional place. They said that working for a public health department is attractive to young people with families, but as that family gets older and becomes more expensive to clothe, feed, educate and house, those employees will leave because they have to follow the money.

Several participants indicated that grant-funded positions are hard to fill because applicants are not eager to accept positions that they know could disappear when funding dries up. As a result, they say, their agencies are reluctant to apply for grants that would result in unstable positions.

Central Partnership for Public Health Staff Focus Groups

Discussion Guide

Group 1

(Tuesday, April 25, 10:30-12:30)

Personal Experience

1. What attracted you to the *field of public health*?
2. What attracted you to your *local health department* as a place of employment?
3. Is the work that you are doing at the health department what you expected when you started working there? (please explain)
4. What are some of the greatest challenges you face as a local public health employee?
5. What motivates you to STAY in local public health?

Recruitment & Retention of Staff

6. Please describe any specific suggestions you have for how local public health departments could encourage the retention of well performing staff?
7. What are some of the reasons you think staff members, such as yourselves, leave local public health agencies?

Personal Goals and Development

8. What are your ultimate goals as a public health professional?
9. What could your agency do to help enhance your professional development?

Central Partnership for Public Health Staff Focus Groups

Discussion Guide

Group 2

(Tuesday, April 25, 1:30- 3:30)

Personal Experience

1. What attracted you to the *field of public health*?
2. What attracted you to your *local health department* as a place of employment? What keeps you there?
3. What are some of the greatest challenges you face in doing your job as a local public health employee?

Health Disparities and Diversity

4. In your opinion how does workforce diversity affect the ability of your organization to address health disparities effectively among African Americans?
5. How could recruitment efforts be targeted to increase the racial diversity in local public health departments?
6. What are some of the reasons you think minority staff members leave local public health agencies?
7. How could the culture and practices of your agency be improved to better support a more racially diverse staff?

Central Partnership for Public Health Staff Focus Groups

Discussion Guide

Group 3

(Friday, April 28, 10:30-12:30)

Personal Experience

1. What attracted you to the *field of public health*?
2. What attracted you to your *local health department* as a place of employment?
3. Is the work that you are doing at the health department what you expected when you started working there? (please explain)
4. What are some of the greatest challenges you face as a local public health employee?
5. What motivates you to STAY in local public health?

Recruitment & Retention of Staff

6. Please describe any specific suggestions you have for how local public health departments could encourage the retention of well performing staff?
7. What are some of the reasons you think staff members, such as yourselves, leave local public health agencies?

Personal Goals and Development

8. What are your ultimate goals as a public health professional?
9. What could your agency do to help enhance your professional development?

Central Partnership for Public Health Staff Focus Groups

Discussion Guide

Group 4

(Friday, April 28, 1:30- 3:30)

Personal Experience

1. What attracted you to the *field of public health*?
2. What attracted you to your *local health department* as a place of employment? What keeps you there?
3. What are some of the greatest challenges you face in doing your job as a local public health employee?

Diversity

4. How does workforce diversity affect your health department's ability to serve the growing Latino population in your local communities?
5. How could recruitment efforts be targeted to increase the number of staff in local public health departments with language abilities and cultural backgrounds that match those of the Latino communities in your counties?
6. What are some of the reasons you think Latino and/or Spanish speaking staff members leave local public health agencies?