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# Minnesota Public Health Corps: A Qualitative Assessment of AmeriCorps' Members Experiences

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**ABSTRACT**

**Context:** Long-standing gaps in public health capacity exist due to extensive workforce shortages, particularly in governmental public health (GPH); these gaps were worsened during and after the COVID-19 pandemic. In response, the federal government established Public Health AmeriCorps (PHA), which supported the integration of AmeriCorps members in public health systems. Minnesota Public Health Corps (MNPHC) prioritized placing members in GPH agencies to increase GPH capacity. Initial evaluation results (2022-2023) suggest that program members were well-integrated into agencies. This article reports on the contextual information offered by MNPHC members throughout their service, including the specific programs and activities members implemented, to better explain how members were successful at extending agencies' capacity.

**Objectives:** Activities, challenges, and successes of members during their service are described to better explain how members were successful at extending their sites' capacity.

**Design:** Descriptive qualitative methods using data reported each month by 60 members.

**Setting:** GPH agencies with at least one AmeriCorps member.

**Participants:** MNPHC members and GPH agencies.

**Intervention:** MNPHC members at GPH agencies across Minnesota who implemented service plans.

**Main Outcome Measure:** Outcomes of interest included salient themes within MNPHC members' (1) activities, (2) encountered challenges and barriers, (3) successes.

**Results:** MNPHC members implemented public health activities that helped bolster the capacity at host sites. The most common activities were related to public health communications, community engagement, and data analysis. Reported successes were largely concerned with progress made on the different activities being implemented by members. Members also reported few challenges; however, most reported challenges related to common issues encountered in public health, such as difficulty working with community partners or finding available data.

**Conclusions:** MNPHC offers a compelling model that provides support to the GPH workforce while also offering those considering a career in GPH an opportunity to experience a range of public health activities.

**KEY WORDS: community health, public health capacity, public health workforce**

## Introduction

Sustained support for governmental public health in the United States (U.S.) is desperately needed. The U.S. has poor population-related health outcomes relative to peer countries and a leading cause is the significant lack of investment in and coordination of public health programming that improves population health.[1,2] The state and local health agencies that comprise governmental public health are responsible for implementing foundational, evidence-based public health services that help prevent illness and promote good health.[3,4] Evidence suggests that better support for improving governmental public health capacity, defined as an agency's ability to provide a suite of necessary public health services to communities, would improve community health.[5] Despite their importance, U.S. governmental public health agencies lack capacity to fully implement public health programming and services because of a corresponding lack of financial resources and available workforce.[6] One study estimated that governmental public health needed an additional 80,000 more full-time equivalent positions just

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*The authors would like to thank our colleagues at Ampact and ServeMinnesota for their ongoing support in completing this study.*

*Supplemental digital content is available for this article. Direct URL citation appears in the printed text and is provided in the HTML and PDF versions of this article on the journal's Web site (http://www.JPHMP.com).*

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*DOI: 10.1097/PHH.0000000000002145*

to provide the basic set of foundational public health services prior to COVID-19.[7,8] Supporting such positions would likely cost an additional $10 billion per year.[8]

Consistent with the lack of public investment, governmental public health has also seen high declines in its workforce size over the past several decades nationwide. In the 10 years prior to the COVID-19 pandemic, 15% to 20% of the governmental public health workforce permanently left and were not replaced, primarily due to cuts in available funding.[7,9] From 2019 to 2022 there was an approximate 19% growth in the workforce.[10] However, this growth was due to temporary COVID-19 pandemic response funding for bolstering the public health workforce.[10] The governmental public health workforce also relies heavily on older workers, many of whom are on the verge of retirement.[11] Young professionals are not envisioning careers in governmental public health, with 75% of those under the age of 35 leaving governmental public health positions between 2017 and 2021.[12,13] The pandemic also exacerbated governmental public health capacity gaps due to an overburdened workforce tasked with controlling the spread of COVID-19 while also operating in a politically charged environment.[14]

These governmental public health workforce shortages highlight the acute need to reinforce the governmental public health workforce, especially for young professionals that might be inclined to pursue a career in a governmental public health setting. Governmental public health has not been successful at attracting younger professionals, despite an increase in the number of people pursuing graduate degrees in public health, and despite many of these graduates expressing an interest in governmental public health careers.[15,16] Many of the perceived strengths of a governmental public health career—eg, stability, good benefits—have degraded relative to other career avenues.[17] Governmental public health careers can also be difficult to enter into, with longer and more bureaucratic hiring procedures, which engenders a perception of governmental public health work among young professionals as stifling and uninventive.[15,17] Facilitating a pathway for young professionals to experience working in governmental public health by integrating them into the day-to-day work of governmental public health agencies might help encourage these professionals to consider working in governmental public health, while also providing those governmental public health agencies with help to address any capacity issues.

In response to the need to shore up the nation's public health system, the Centers for Disease Control & Prevention (CDC) and AmeriCorps established a joint initiative in 2021: Public Health AmeriCorps (PHA). PHA had two goals: (1) increase the public health workforce by initiating an interest in public health careers, particularly among young professionals, by offering experiential opportunities in public health; and (2) improve public health capacity by expanding the number of people working in public health.[18] As of September 2024, PHA has supported 6500 members engaging in various services (eg, chronic disease prevention, mental health support, etc.) while serving in health departments, community organizations, clinics, and other public health settings across the country.[19]

## Minnesota public health corps background

In Minnesota, one of the largest models funded by PHA has adopted a singular approach that focuses on placing members in governmental public health settings to support public health activities and improve governmental public health capacity. This has been unique among PHA grantees; many other grantees have integrated members into a range of different organization types and/or focused on providing specific public health services. Minnesota Public Health Corps (MNPHC) is comprised of three implementing organizations: ServeMinnesota (Minnesota's AmeriCorps State Service Commission), Ampact (the nonprofit organization managing and implementing the program), and the University of Minnesota School of Public Health (supporting with content expertise, training, and evaluation). In its first year, MNPHC had 63 members at 35 host sites. Table 1 provides the summary

**TABLE 1**
**Minnesota Public Health Corps Member Demographics**

| Characteristic | Percentage |
|---|---|
| Gender | |
| Female | 81% |
| Male | 17% |
| Non-binary | 2% |
| Age | |
| 18-24 | 62% |
| 25-34 | 27% |
| 35-44 | 3% |
| 45-54 | 6% |
| 5-64 | 2% |
| Ethnicity | |
| Asian | 8% |
| Black or African-American | 22% |
| Hispanic or Latino | 2% |
| Two or More Races | 6% |
| White | 63% |

information on the members. Each host site worked with members to design a service plan that was feasible for members to implement and meet their public health programming needs. Part of MNPHC's implementation design also focused on providing extensive, ongoing administrative support to members to ensure site supervisors were able to devote their management efforts towards guiding members on their public health-related work. Members were also given comprehensive training in important public health concepts, providing knowledge, skills, and abilities necessary to work in public health even without previous background. After the first year of implementation, sites that hosted members reported improvements in capacity to provide public health services despite growing needs. Additionally, members reported experiencing positive growth and 79% intended to pursue a public health career. For further information on MNPHC's first year evaluation results, please see Kirkland et al.[24]

### *Purpose*

While it is instructive to note the promise of members expanding governmental public health capacity, the specifics of implementation—what public health programming was implemented by members, what programmatic or administrative challenges arose during their year, and where members found success—is also integral to understanding how the program can be replicated elsewhere and/or improved by providing context to the experiences at governmental public health agencies. Characterizing members' reports of their service activities will offer further insights into what made the MNPHC model successful and potentially provide generalizable lessons to other PHA grantees interested in improving governmental public health capacity. Understanding what activities were completed by members also provides insights into where capacity was needed most within governmental public health agencies and can inform recommendations for future internship programming that is also supportive of governmental public health capacity needs.

## Methods

The data included in this study came from members' service plans and monthly reports. The service plans were narrative descriptions of planned activities developed between members and their host agencies prior to the members' service terms, although members were also allowed to assist with activities that were not outlined in these plans. The monthly reports were submitted by members via electronic survey and asked members what they were doing at their sites; any associated issues or challenges associated with those activities that might require program managers to intervene; and/or any successes associated with those activities that they wanted to note. Authors HS and CK began by deductively coding the service plans and member monthly plan data[20] into the 10 Essential Public Health Services (EPHS).[21] Authors JF and RP then inductively coded members' activities, challenges, and successes (within and outside of their site service plans) using a combination of descriptive and *in vivo* coding and thematic analysis.[22] Codes were not exclusive and some data was double-coded since public health work is often multidimensional and cross-cutting. All data analysis was completed using NVivo.

The 10 EPHS is a well-recognized framework for defining the set of public health services all communities should have available. Each EPHS is within one of three core functions of public health practice: assessment of health conditions and potential threats in the community; policy development that advances and promotes population health; and assurance that critical public health provisions are continually made available to communities and individuals.[23] Our findings are organized within these three domains. Further details on how the 10 EPHS framework was used to develop our coding can be found in the Supplementary Digital Content, available at: http://links.lww.com/JPHMP/B500.

## Results

As delineated in Tables 2 and 3, there were a total of 444 monthly service reports from 60 members in the first year of MNPHC. Members reported working on projects and developing public health skills within a range of activities. Most (73%) monthly activities related to work specified within members' service plans. For activities within the purview of site service plans, the most common activities were communications (n = 319 references), followed by community engagement (n = 309), and data collection (n = 262). Using the EPHS framework to categorize the activities, most of the service plan activities fell within assurance (n = 1072 references), followed by policy development (n = 871) and assessment (n = 388). For non-service plan activities, meetings (n = 92 references) were the most common activities, followed by data collection (n = 86) and data analysis (n = 81). Non-service plan activities were largely grouped in assurance (n = 507) (Tables 2, 3, and 4).

### *Member activities*

Overall, the most common service plan activities were communications (319 references), community

**TABLE 2**
**Service Plan-related Categories and Theme Frequencies**

| EPHS Domain | Activities (# of references) | Successes (# of references) | Challenges (# of references) |
|---|---|---|---|
| Overall | Communications (319) | General progress (238) | No challenges (650) |
| | Community engagement (309) | Community engagement (169) | Communications (84) |
| | Data collection (262) | Data collection(169) | Data collection (76) |
| Assessment | Data collection (96) | Data collection (64) | No challenges (156) |
| | Data analysis (46) | General progress (36) | Resources (21) |
| | Meetings and committees (39) | Data analysis (27) | Communications and engagement (10) |
| Policy Development | Community engagement (157) | Community engagement (101) | No challenges (174) |
| | Communication (157) | Communication (76) | Time (26) |
| | Meetings (71) | General progress (62) | Inexperience (16) |
| Assurance | Communications (158) | General progress (132) | No challenges (320) |
| | Community engagement (132) | Data collection (81) | Communications (62) |
| | Data collection (124) | Community engagement (68) | Community engagement (45) |

engagement (309 references), and data collection (262 references; Table 2). Within the EPHS domains (ie, assessment, policy development, and assurance) the most common activities were data collection (96 references), community engagement (157 references), and communications (158 references), respectively (Table 2).

Within communications and community engagement activities, members were focused on educating and engaging the public on a certain health topic and/or on available public health services. For example, one member said they had "Researched, planned campaigns, and wrote social media posts for upcoming women's health related observances and other posts that raise awareness about new resources available to the public." Other members helped liaise with multiple groups at once: "Most of the community engagement and communication we have done so far has been reaching out to different stakeholders across various fields in the county…to get more insight and information regarding opioid use and cases in our county."

The nature of members' data collection and data analysis activities also varied. Many members collected data for evaluation or quality improvement purposes, which were categorized as assurance. For example, one member was tasked with helping evaluate an intervention that encouraged children to increase their physical activity by walking or biking to and from school: "I have collected secondary data on walking and biking but I still need to gather primary data through observation." Some members reported working on health assessments for the general population, such as through a community health assessment (CHA) and/or a community health improvement plan (CHIP). One member stated that

**TABLE 3**
**Non-service Plan-related Categories and Theme Frequencies**

| EPHS Domain | Activities (# of references) | Successes (# of references) | Challenges (# of references) |
|---|---|---|---|
| Overall | Meetings (92) | Data (44) | No challenges (263) |
| | Data collection (86) | Planning (43) | Data (23) |
| | Data analysis (81) | Data analysis (29)/General progress (29) | Inexperience (21) |
| Assessment | Data collection (53) | Data (44) | No challenges (48) |
| | Data analysis (19) | Organization (11) | Data (12) |
| | Research (16) | Project (5) | Organization (6) |
| Policy Development | Document creation or updating (8) | Document creation or updating (5) | No challenges (22) |
| | General communication (4) | Community engagement (3) | Bureaucratic process (4) |
| | Social media (4) | Planning (3) | Scope (4) |
| Assurance | Meetings (86) | Planning (36) | No challenges (193) |
| | Training (60) | Data analysis (29) | Inexperience (12) |
| | Planning (56) | General progress (25) | Data (11) |

**TABLE 4**
**Sample Quotes from Minnesota Public Health AmeriCorps Members**

| EPHS Domain | Example Activities | Example Successes | Example Challenges |
|---|---|---|---|
| Assessment | "This last month I have begun looking into mental health practices by counties and have met with a few county mental health advisory councils. They were able to walk me through what they do and challenges they run into and gaps in mental health resources for counties." | "Using statistical data to look at certain health outcomes and comparing them to the overall population has been informative to me to learn health disparities and how our approaches can be tailored to the needs of the community." | "All the data sets we needed were not available or did not exist." |
| | "I've been collecting data on organizations that combat youth and group violence in the community, as well as collecting information needed for an upcoming conference." | "Increased community engagement in surveys, improved quality of data collected, and successful implementation of evidence-based health interventions" | "It sometimes has been hard to jump into a project that has already been started and be expected to know a lot about it and continue it but that has been something I've worked through with my site" |
| | "I have looked at different data I have collected for the community health needs assessment. I analyzed and interpreted it to write a brief description about it." | "Another big milestone is starting to work directly with counties to help them with resource and planning" | "One of the challenges I have encountered…is the need to adapt to a rapidly changing environment. As the COVID-19 pandemic has disrupted traditional methods of outreach, I have had to quickly adjust my approach and find new ways to engage local stakeholders" |
| Assurance | "Met with community outreach teams regarding disease exposure/ activities and learned more about techniques and strategies to increase engagement in the community to address immunization and vaccine hesitancy" | "I have been able to take part in many different aspects of community engagement. Giving presentations about researched topics, being a part of community partnerships and projects, working community events focused on SHIP work, working with county cultural ambassadors, and attending meetings and presentations from other counties and organizations." | "One of the challenges I have encountered is the need to ensure accuracy and completeness of data. To ensure that the data collected are accurate and comprehensive, I have had to be vigilant in double-checking and verifying the data collected." |
| | "I spent time collecting data and planning for the Health Equity Community Engagement Committee, Community Health Assessment, and Racial Equity Learning Committee." | "I have had meetings with community members for the improvement plan and used their inputs in the assessment." | "We realized that staffing changes have caused delays or cancellations in project implementation and that momentum was being lost when the community champion familiar with the work had moved elsewhere." |
| Policy Development | "I have been actively training to better understand policy as well as follow what has been happen [sic] in the house and senate. I frequently find webinars to join and workshops to develop my leadership and knowledge in public health for my future path." | "I created 6 posts in May for 2 different campaigns that will be posted soon. In total, I have written at least 20-25 social media posts so far." | "Even though counties and cities are required by Minnesota Law to minimally match the language found in state law; the willingness of cities and counties of prioritize [sic] this work, and the response times of city and county officials is often less than what I'd like." |
| | "Much of our work over the last month has really focused on working with the Public Health Law Center to create clean drafts of ordinances that include the provisions requested by city councils; to subsequently send | "I have developed a better understanding of professional public health communications and have developed skills that keep in mind reading ability and possible visual impairments." | "A big challenge is getting all schools to participate in the assessment. Some schools may not have the capacity for it or the tools for it… however, without a sufficient amount of schools participating, especially ones in key areas that |

(*continues*)

**TABLE 4**
**Sample Quotes from Minnesota Public Health AmeriCorps Members (*Continued*)**

| EPHS Domain | Example Activities | Example Successes | Example Challenges |
|---|---|---|---|
| | those clean copies to the city for final review and subsequent posting for public comment." | | represent any given group within the community, the proper statistics may not be given." |
| | "The bulk of this work has centered on working with counties and cities to update their tobacco retailer ordinances." | "I meet with community partners constantly and sit on the meetings of several local coalitions to keep the public health department involved and informed of the work that is being done." | "I think the challenge that comes to mind is learning to manage the speed at which the county local government works versus the pace at which some nonprofits and community partners want to proceed. It takes a lot of balance and communication from both sides to set those expectations." |

they were "Working on the CHA/CHIP, Workforce Development Plan for my site, and assisting with the CHB Staff Survey results." Other members' activities included data collection or analysis related to a specific health domain: "Data collection for sites with potentially hazardous materials and mapping proximity to nearby sites and how spills or fires could impact community."

Members also frequently reported multiple different activities within the same monthly report, such as this member that reported communications, community engagement, and data collection activities:

> "I am meeting on a daily basis with various community partners on topics like opioids, mental health, vaping/tobacco use, food availability, and more. This month, I was also in charge of running a blood drive for the county, assisting with a BIPOC listening session, and am helping plan a naloxone training event for early April with a local coalition."

Other members that reported working within a single category had worked on many different activities: "I have been able to take part in many different aspects of community engagement. Giving presentations about researched topics, being a part of community partnerships and projects, working community events focused on SHIP work, working with county cultural ambassadors, and attending meetings and presentations from other counties and organizations." As part of their service term, members were well-integrated into the public health operations of their host agencies.

Non-service activities were more concerned with the day-to-day work of being integrated within members' public health agency host sites. Meetings were the most common non-service plan activity, and members frequently were called to participate or organize meetings and events. For example, a member described assisting their agency with planning for a new grant-funded service, "I have been involved in team meetings to understand a new program that is being launched… In preliminary planning phase to develop communications plan for the project." Even though members listed meetings as the most common activity outside of their service plans, these meetings were then often tied to other projects that were within their service plans.

### *Successes*

Members' most common successes were general progress (238 references), community engagement (169 references), and data collection (169 references; Table 2). The most common successes within the EPHS domains (ie, assessment, policy development, and assurance) were data collection (64 references), community engagement (101 references), and general progress (132 references), respectively (Table 2). For those working with data, for example, many members' successes were often observing the benefits of completing data-related tasks. One member was excited because they saw the fruition of their work: "We have spent a while analyzing the data and came up with three ways we could improve benefit utilization. We are hoping to implement all three this season, with two of those pretty much in place." For members engaging with community members and organizations, success was linked to realizing progress and appreciating the skills they were developing: "I have been able to take part in many different aspects of community engagement. Giving presentations about researched topics, being a part of community partnerships and projects, working community events focused on SHIP work, working with county cultural ambassadors, and attending meetings and

presentations from other counties and organizations." Successes, both big and small, were critical to building members' confidence in their public health skills.

### *Challenges*

The most common response from members to the monthly query about challenges faced related to service plan activities was "no challenges" (653 references, overall; 156 references, assessment; 174 references, policy development; and 320 references, assurance). Once these responses were removed, members' most common issues were related to communications (84 references) and data collection (76 references). The challenges experienced within the EPHS domains (ie, assessment, policy development, and assurance) were resources (21 references), time (26 references) and communications (62 references).

Members working on communications and community outreach primarily found difficulties in working with multiple partners and finding consensus: "Not unexpectedly, it's challenging to build consensus amongst project stakeholders, and as more stakeholders are included in the project…building and maintaining that consensus will become more challenging." Some members also noted the difficulty of collaboration when under significant constraints: "We realized that staffing changes have caused delays or cancellations in project implementation and that momentum was being lost when the community champion familiar with the work had moved elsewhere."

Members working with data collection and/or analysis reported challenges largely centered on typical data-related issues, such as a lack of granularity for their location and/or for their topic of study. One member who was tasked with analyzing data related to the legalization of cannabis noted that, "Finding information on cannabis poisonings, testing, and inspections has proved challenging. Because this is illegal at the federal level and states are just beginning to legalize cannabis in very different ways, it is difficult to find research and data on some information". Other members experienced challenges with finding data specific to their location, particularly for those serving rural counties: "I think the biggest challenge is the lack of data in a smaller, more rural areas like mine… There are also issues when it comes to reporting from local hospitals and first responders, with there being a lack of infrastructure requiring/enabling these entities to report overdose and other data." These data issues are prevalent throughout public health and provide members with first-hand experiences of sector-wide data challenges.

Many members noted challenges with available resources and time. For example, one member "… didn't have access to some mapping tools, that could have been beneficial for presenting…information or highlighting focus areas." However, they "found a [sic] alternative" to address the issue. Members also noted experiencing delays and not having sufficient time to work on their projects. One member noted that "The biggest challenge for all of these [partnering] groups is finding the time and resources necessary to begin implementing these strategies in an effective manner." Another member spoke on delays they experienced stating that, "Sometimes projects get pushed back for a long time and when this happens it's hard to remember about them. I have to go back and remember what I'm supposed to be doing." Sufficient time and resources were ongoing challenges that required members to be both flexible and creative in how they approached their work.

## Discussion

MNPHC members implemented a range of standard public health activities for governmental public health host sites during their service term. Most of this work involved public health communications, community engagement, and data collection. Members also frequently worked across multiple EPHS domains and helped address a range of different health challenges of those residing in their communities. The successes that members reported were largely ongoing progress made in their work, as well as appreciation for gaining new skills and experiences. The challenges that members experienced were also typical of governmental public health agencies and/or relevant to those working in public health, such as finding appropriate data for a given topic or dealing with time and resource constraints with community partners. Notably, members did not report any general or specific issues with MNPHC administrative burdens. While it may be that members did not feel comfortable reporting such issues directly to staff, it may also be that MNPHC's unique model of assuming much of the administrative oversight of members ensured members and their site supervisors the space to focus on implementation of public health projects. Members had program coaches assigned to them from MNPHC that they met with periodically and could go to for any administrative issues that arose during their service term.

From an oversight perspective, the monthly reporting from members provided an opportunity to make programmatic improvements in how MNPHC operates. For example, more comprehensive training on data collection and analysis, public health communications,

and how to successfully engage with community stakeholders have been added to the initial onboarding process because of how many members worked on projects in these areas. For those who may be considering a similar model program, adjusting the training materials to fit the needs of governmental public health agencies and their members may improve participation in PHA from both members and sites.

More broadly, these initial results from MNPHC illustrate how well many of the governmental public health agencies were able to incorporate their members into their day-to-day workflow and had them working on critical public health activities that are performed at governmental public health agencies across the country, which supports the replicability of the program. All the projects that members worked on were fundamental public health services that helped agencies improve what they were able to provide to communities—and which might help explain at least some of the observed capacity gains.[24] All agencies reapplied for members again for the following program year (2023-2024), with some requesting additional members. Several new agencies also applied to host members, all of which found MNPHC effective and helpful.

For those looking to establish a similar career pathway program to governmental public health and/or finding innovative ways to support their own health agencies, these initial results from MNPHC are promising. For one, MNPHC has been able to provide needed support to governmental public health agencies by facilitating the implementation of common public health activities, while also encouraging young professionals to consider careers in governmental public health. The challenges faced by MNPHC members, such as difficulty working with community partners or finding appropriate data, are also typical problems faced frequently by public health professionals—again suggesting this model is able to focus on supporting public health work, rather than administrative issues with implementing the program. While there may be additional administrative and logistical barriers to establishing a similar program, these results suggest that the MNPHC model is potentially adoptable in other states.

There are limitations to this study that should be noted. For one, Minnesota has a high level of existing support provided to its governmental public health system, frequently ranking in the top 10 states with the highest per capita spending on public health.[25] Like most other states, Minnesota's governmental public health agencies are in need of significant workforce support post-COVID[26]; however, it may be that MNPHC's positive experiences are unique and difficult to replicate elsewhere due to this existing support. There are also limitations in interpreting narrative directly from members, which may not always reflect their actual experiences. For example, while no members reported significant administrative challenges, some members may have had issues with how MNPHC provided administrative support that they felt uncomfortable reporting. Lastly, some of the described activities, challenges, and successes may be more directly related to working in public health at that particular time (ie, during and immediately after COVID-19 pandemic). As such, members' experiences and subsequent activities, successes, and challenges, may change over time alongside the rest of the workforce. More assessment of the MNPHC model is needed before making definitive conclusions about the effects of members on governmental public health capacity or the generalizability of the program.

### Implications for Policy and Practice

- PHA represents a critical lifeline to support and expand the governmental public health capacity in the United States at times when public health professionals and agencies are still recovering from the detrimental effects of the COVID-19 pandemic and decades of funding loss.
- Testimonials from MNPHC members confirm that the scope of activities they implemented were critical public health services, which are needed for governmental public health agencies to function. Members were especially supportive of community engagement and communication, as well as data collection and analysis.
- Other potential PHA grantees may want to consider adopting a similar model as MNPHC that also focuses on governmental public health.

## Conclusion

The testimonials from MNPHC members detailing the activities, challenges, and successes that they experienced in their service term suggest that PHA is well-suited to supporting governmental public health. Given the significant documented workforce-related needs of governmental public health agencies in the U.S., this type of program may be adept at both bolstering the public health system and encouraging professionals to pursue a career in public health.

## References

1. National Research Council, Committee on Population. *US health in international perspective: shorter lives, poorer health.* Published online 2013.
2. Simone S. Public health spending and population health: a systematic review. *Am J Prev Med.* 2014;47(5). doi:10.1016/j.amepre.2014.05.017.

3. Gebbie KM. The public health workforce: key to public health infrastructure. *Am J Public Health*. 1999;89(5):660-661. doi: 10.2105/AJPH.89.5.660.
4. Leider JP, Yeager VA, Kirkland C, Krasna H, Hare Bork R, Resnick B. The state of the US public health workforce: ongoing challenges and future directions. *Annu Rev Public Health*. 2023;44(1):323-341. doi:10.1146/annurev-publhealth-071421-032830.
5. Schenck AP, Meyer AM, Kuo TM, Cilenti D. Building the evidence for decision-making: the relationship between local public health capacity and community mortality. *Am J Public Health*. 2015;105(S2):S211–S216. doi:10.2105/AJPH.2014.302500.
6. Baker EL, Potter MA, Jones DL, et al. The public health infrastructure and our nation's health. *Annu Rev Public Health*. 2005;26(26):303-318. doi:10.1146/annurev.publhealth.26.021304.144647.
7. de Beaumont Foundation, Public Health National Center for Innovation. *Staffing Up: Investing in the Public Health Workforce*. de Beaumont Foundation. Accessed October 11, 2024. Available from: https://debeaumont.org/staffing-up/
8. Leider JP, Mac Mccullough J, Singh SR, et al. Staffing up and sustaining the public health workforce. *J Public Health Manag Pract*. 2023;29(3):E100–E107. doi:10.1097/PHH.0000000000001614.
9. Kumar P, Lurie E, Parthasarathy R. *Building the US Public-health Workforce of the Future*. Washington, DC:McKinsey and Company; February 2, 2022. Accessed October 11, 2024. Available from https://www.mckinsey.com/industries/public-sector/our-insights/building-the-us-public-health-workforce-of-the-future#/
10. Cunningham M, Patel K, McCall T, et al.*2022 National Profile of Local Health Departments*.National Association of County & City Health Officials. Accessed December 3, 2024. https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments
11. Leider JP, Sellers K, Bogaert K, Liss-Levinson R, Castrucci BC. Voluntary separations and workforce planning: how intent to leave public health agencies manifests in actual departure in the United States. *J Public Health Manag Pract*. 2021;27(1):38-45. doi: 10.1097/PHH.0000000000001172.
12. Leider JP, Castrucci BC, Robins M, et al. The exodus of state and local public health employees: separations started before and continued throughout COVID-19: study examines state and local public health agency employees intent to leave or retire in 2017 with actual separations through 2021. *Health Aff (Millwood)*. 2023;42(3):338-348. doi:10.1377/hlthaff.2022.01251.
13. Sellers K, Leider JP, Gould E, et al. The State of the US Governmental Public Health Workforce, 2014–2017. *Am J Public Health*. 2019;109(5):674-680. doi:10.2105/AJPH.2019.305011.
14. Stone KW, Kintziger KW, Jagger MA, Horney JA. Public health workforce burnout in the COVID-19 response in the US. *Int J Environ Res Public Health*. 2021;18(8):4369. doi: 10.3390/ijerph18084369.
15. Locke R, McGinty M, Ramirez GG, Sellers K. Attracting new talent to the governmental public health workforce: strategies for improved recruitment of public health graduates. *J Public Health Manag Pract*. 2022;28(1):E235–E243. doi: 10.1097/PHH.0000000000001336.
16. Plepys CM, Krasna H, Leider JP, Burke EM, Blakely CH, Magaña L. First-destination outcomes for 2015–2018 public health graduates: focus on Employment. *Am J Public Health*. 2021;111(3):475-484. doi:10.2105/AJPH.2020.306038.
17. Krasna H, Fried L. Generation public health: fixing the broken bridge between public health education and the governmental workforce. *Am J Public Health*. 2021;111(8):1413-1417. doi:10.2105/AJPH.2021.306317.
18. AmeriCorps. *Public Health AmeriCorps*. Washington, DC: AmeriCorps. Accessed October 11, 2024. Available from: https://americorps.gov/serve/americorps/americorps-state-national/public-health-americorps
19. AmeriCorps. *Public Health AmeriCorps Fact Sheet*. Accessed December 10, 2024. Available from: https://p1.aprimocdn.net/americorps/d647ff8c-9996-48ad-86a7-b21a000981f4/20241030_pha_fact-sheet_8.5x11-original-file.pdf
20. Johnson RB, Christensen LB. *Educational Research: Quantitative, Qualitative, and Mixed Approaches*. Sage Publications; 2024. Accessed October 11, 2024
21. Public Health Accreditation Board. *The 10 Essential Public Health Services*. Public Health Accreditation Board. Accessed October 11, 2024. Available from: https://phaboard.org/center-for-innovation/public-health-frameworks/the-10-essential-public-health-services/
22. Saldaña J. *The Coding Manual for Qualitative Researchers*. Published online 2021. Accessed 2024 October 11
23. Perry IA. Assessment, policy development, and assurance: evolving the core functions of public health to address health threats. *AJPM Focus*. 2024;3(1):100172. doi:10.1016/j.focus.2023.100172.
24. Kirkland C, Stabler H, Frank J, et al. Minnesota Public Health Corps: a new model for building the governmental public health workforce. *Health Aff (Millwood)*. 2024;43(6):822-830. doi:10.1377/hlthaff.2024.00019
25. State Health Access Data Assistance Center. Accessed October 11, 2024. https://statehealthcompare.shadac.org/
26. The Joint Leadership Team for Public Health System Transformation. *Cost and Capacity Assessment: key Findings and next Steps*. 2023. Accessed October 11 2024. Available from: https://www.health.state.mn.us/communities/practice/systemtransformation/docs/202310costcapacity-memoreport-reduced.pdf