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Centers for Disease Control and Prevention's Public Health Infrastructure Grant: A Better Approach to Empowering More State and Local Decision Making and Strengthening the Public Health Workforce and Infrastructure

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Abstract

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Context: In response to the COVID-19 pandemic, Congress passed the American Rescue Plan Act of 2021 (ARPA) that included a historic investment in the public health workforce.

Program: Charged with implementing this investment, the U.S. Centers for Disease Control and Prevention (CDC) launched the Public Health Infrastructure Grant (PHIG). PHIG builds on CDC's experience working with state, local, and territorial public health departments and represents a new approach to strengthening the public health workforce.

Implementation: Specifically, PHIG incorporates features that allow these public health departments to prioritize and tailor the funding to meet their communities' needs: 1) focus on workforce as core infrastructure, 2) streamlined programmatic and administrative requirements, 3) more equitable funding approach, and 4) enhanced support from national partners and CDC.

Discussion: The goal is to optimize the unprecedented opportunity afforded by ARPA and lead to a stronger public health workforce and infrastructure across the United States.

Keywords

funding; governmental public health workforce; public health infrastructure

Introduction

The COVID-19 pandemic presented serious challenges to the public health workforce and system and galvanized efforts to further invest in them.^{1–3} The American Rescue Plan Act of 2021 (ARPA) was one such investment. Through ARPA, Congress allocated unprecedented billions of dollars to award to state, local, and territorial health departments to support their public health workforce (ARPA, Sec 2501). Hundreds of millions more dollars were earmarked to support public health data modernization efforts (ARPA, Sec. 2404), among its many provisions.⁴ These investments were historic in size and scale.

The Centers for Disease Control and Prevention (CDC)'s response to this Congressional mandate was the development of the OE22–2203 Strengthening US Public Health Infrastructure, Workforce, and Data Systems grant (abbreviated to the Public Health Infrastructure Grant or PHIG for the remainder of this paper).⁵ The purpose of this study is to describe PHIG's design to a broader audience, because we believe PHIG represents a notable development in how CDC seeks to support the governmental public health workforce and infrastructure. In addition to its significant funding levels, PHIG blends features that allow these public health departments to prioritize and tailor the funding to meet their communities' needs. The goal is to optimize the unprecedented opportunity afforded by ARPA and accelerate the path toward a stronger public health workforce and infrastructure across the United States.

The Public Health Infrastructure Grant: Origins and Overview

The design of PHIG began during fall 2021 and included a series of 8 listening sessions with a wide range of public health partners to better understand their perspectives at this critical juncture of the pandemic. With this input in mind and lessons of the COVID-19 pandemic still fresh, CDC staff approached the design of this funding mechanism with a desire to create a grant that could have lasting effects not only on recipient health departments but

also on CDC's approach to funding. CDC sought to use the unique opportunity afforded by ARPA to better empower recipients to use funds to address each of their unique and most critical needs, capitalizing on both administrative and programmatic flexibility provided. Four key features of the grant allowed for this enhanced flexibility including: (1) focus on workforce as core infrastructure, (2) streamlined programmatic and administrative requirements, (3) more equitable funding approach, and (4) enhanced support from public health national partners and CDC.

The initial Notice of Funding Opportunity announcement was released on [Grants.gov](https://www.grants.gov) on June 23, 2022, and the first Notices of Award were issued in November 2022. The basic design, funding sources, and recipients are summarized in Table 1. The program has a 5-year performance period and includes 2 components. Component A was awarded to 107 jurisdictions, including states, big cities, counties, and territorial health departments or their bona fide agents. Funding from component A supports strategies regarding workforce (A1), which constituted most of the investment and focus; foundational capabilities (A2); and data modernization, which includes wide ranging data systems strengthening (A3).⁶ Component B was awarded to 3 national partners to support strategies for providing training and technical assistance (T/TA) to component A recipients for A1, A2, and A3 strategies, evaluating the grant, and facilitating coordination and communication among all recipients. These partners are the Association of State and Territorial Health Officials, the National Network of Public Health Institutes (NNPHI), and the Public Health Accreditation Board (PHAB), each of which works with numerous sub-partners.

Relatively unique to PHIG is the fact that year 1 funding blended funding from various sources, and the time frames for funding availability varied. For example, the ARPA funds are multiyear funds that are available for 5 years. The funds from the annual Public Health Infrastructure and Capacity appropriations are available for 1 year. Also, CDC awarded the funding for data modernization 6 months later than the workforce and foundational capabilities strategy funding to a subset of component A recipients (64/107).

Four Features That Together Make the Public Health Infrastructure Grant Different

Feature 1: Focus on workforce as core infrastructure—ARPA's public health workforce provisions prompted initial work on PHIG, but in early phases of grant development, CDC adopted a broader infrastructure framework, with workforce at the core. For the governmental sector, this infrastructure framework is most clearly articulated in the 8 foundational capabilities within the Foundational Public Health Services.⁷ This includes assessment and surveillance, community partnership development, equity, organizational competencies, policy, performance management, emergency preparedness response, and communications. What underlies all of these functions, systems, and services is the public health workforce. PHIG centers around the governmental workforce as its primary focus and as the primary means to realizing these foundational capabilities. In this way, PHIG differs from many other CDC funding opportunities, which are disease, condition, or population specific. Accordingly, under each strategy, the scope of activities allowed is wide, to ensure the effects can reach the foundations of the public health infrastructure. For example, supporting the workforce includes not only hiring but also retention,

professional development, engagement, workforce wellness, and strengthening relevant workforce systems.

The underlying theory of change is that this investment in workforce, alongside other improvements to each recipient's public health infrastructure, will result in improved response to emergency health threats and public health outcomes more broadly (Figure 1). Health equity and diversity, equity, inclusion, accessibility, and belonging were conceptualized as essential, crosscutting principles to be integrated across PHIG implementation, rather than called out as separate strategies.

Several CDC programs have funded health departments to broadly build and implement core infrastructure, including developing the workforce, but for more focused purposes. For example, for years, CDC's Epidemiology and Laboratory Capacity program has supported this in relation to domestic infectious diseases; the Public Health Emergency Preparedness program has done so in relation to emergency response capacity.^{8,9} More recently, OT21–2103 National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (abbreviated as the COVID-19 health disparities grant below) and TO-23–001: Strengthening Public Health Systems and Services in Indian Country both explicitly seek to address the core infrastructure and workforce needs related to health equity and to American Indian and Alaska Native tribes, respectively.^{10,11} However, PHIG goes farther, not only in its scale but also by including an even more explicit and comprehensive focus on workforce and infrastructure than most prior or current efforts. PHIG arguably allows recipients to address workforce and infrastructure weaknesses directly and in a more holistic way.

Feature 2: Streamlined programmatic and administrative requirements—CDC layered this broad scope with streamlined grant requirements. This combination of features 1 and 2 provides recipients with powerful flexibility and thus enhanced agency. CDC's experience with other highly flexible funding mechanisms, in particular CDC's Preventive Health and Health Services (PHHS) Block Grant, paved the way for this approach.¹² The PHHS Block Grant is a community-driven grant that allows funded health departments to use the funds to address any of the objectives aligned to the Health People 2030 framework, including public health infrastructure.

The list of required activities for component A recipients in PHIG is highly focused: (1) to expand their workforce to some extent, given emphasis on this in authorizing legislation; (2) to support a high-level workforce director, to elevate cross cutting workforce strategy and implementation; and (3) to provide evaluation expertise for the grant, to ensure recipients' capacity to monitor and evaluate work under PHIG. State health departments also must allocate at least 40% of the workforce funding to local health departments not directly funded by the grant. Beyond that, recipients can direct the funding within each of the 3 strategy areas in ways that serve their needs best. For its part, CDC is committed to supporting recipients' unique needs and to streamlining and minimizing administrative and reporting requirements, to the extent feasible and allowable by law. CDC's choice to use a grant mechanism rather than the more typical cooperative agreement mechanism for PHIG also affords recipients greater flexibility. In general, the less prescriptive approach shown by

the CDC in these requirements means that the recipients have more control to direct funding as needed in their unique jurisdictions.

An additional benefit of flexibility is that it should make it easier for recipients to complement other federal, state, local, and other funding streams. Some funding sources might be more restrictive due to Congressional directives, appropriations language, or limitations attached to their authorizing legislation. Flexible funding such as PHIG can enhance grantee abilities to optimize other funding sources; an example of leveraging this way is described in the context of CDC's injury prevention funding.¹³

This ability to direct and leverage PHIG funding according to recipient needs is clearly reflected in the breadth of activities being implemented across recipients, as evident in their work plans. We randomly selected 4 year-1 workplans from each eligibility category of component A recipients and summarized the work proposed (Table 2). The random selections included a city (Milwaukee, WI), county (Wake County, NC), territory (US Virgin Islands or USVI), and state (Connecticut or CT) health department. For greater comparability, workforce and foundational capabilities information is provided.

All 4 recipients are hiring a senior workforce director and an evaluator, as required. Other hires reflect recipients' needs and range from a clinic operations director (Milwaukee) to a process improvement director (USVI) and program coordinators for health equity partnerships (CT). Across these recipients, some hiring is under workforce (A1) and some is under foundational capabilities (A2). Both Milwaukee and USVI planned to retain several staff funded through other means (eg, a graphic designer, a strategist, a program manager, and a fiscal coordinator), suggesting how PHIG complements other funding streams. Wake County chose to support and train existing staff over adding new hires, compared to the other recipients shown. Some systems and policy changes represented include Milwaukee's and Connecticut's intention to revise job pay scales or review compensation levels (funded under A1 workforce) and USVI's plans to upgrade their HR system (funded under A2 foundational capabilities). Some activities are directed toward specific public health program areas, such as in USVI and Connecticut, which call out new investments in environmental health; most of the other activities across these recipients are crosscutting and foundational, intended to benefit staff across program areas (eg, workforce wellness programs) or to strengthen functions that serve many programs (eg, improved human resource recruitment and grants management). These crosscutting functions can be difficult to support through more categorical or disease-specific funding. Together these examples demonstrate PHIG's workforce and infrastructure focus and its flexibility in action.

Feature 3: More equitable funding approach—This grant adopted the innovation made by the COVID-19 health disparities grant, which funded the largest number of state, territorial, and local public health department recipients (108) through a single grant in CDC's history.¹⁰ By including 49 city and county health departments, 8 freely associated states and territories, and all 50 US states, PHIG reduces steps and costs by awarding more funds directly to the local level rather than through the state first. Many of the local and territorial recipients have not been routinely funded by the CDC through its various other funding mechanisms (eg, El Paso, Texas; Mecklenburg County, NC). This inclusivity as part

of PHIG's funding model further supports more local control and broader representation within the recipient community.

The COVID-19 health disparities grant also led the way on incorporating measures of community vulnerability in the funding formula used to allocate funding, to help direct more funding to where needs were greatest. The formula for PHIG was transparent to applicants and incorporated population size and the US Census Bureau's Community Resilience Estimates to direct allocation amounts.¹⁴ Finally, ARPA's appropriations provisions provided CDC an unusual opportunity to obligate 5 years of funding for workforce up front, allowing recipients more certainty about funding levels throughout the grants' period of performance and more time to plan and implement planned activities. This feature provided them with a longer planning and implementation horizon than the annual funding that is more characteristic of discretionary federal funding and associated with increased administrative burden. As a result, PHIG recipients can pace spending according to their own plans, needs, and capacity during the 5-year period of performance.

The exclusion of tribes as direct applicants to PHIG raised questions about equity. However, because Congress provided significant, specific funding to tribes (managed by the Indian Health Service) through ARPA, tribes were not included as intended recipients of PHIG. To build on this complementary support provided by ARPA, PHIG recipients are strongly encouraged to collaborate with tribal nations and organizations in their jurisdictions.

Feature 4: Extensive support—Despite a limited time frame for developing PHIG, CDC conducted 8 listening sessions with different public health partners at local, state, and national levels concerning their workforce needs. These sessions provided an additional source of information for designing the grant and reinforced decisions regarding flexibility. Holding these sessions reflected CDC's desire to manage PHIG differently and establish an expectation of high levels of engagement, inclusivity, and partnership from the start.

Component B of PHIG supports national partners in providing T/TA to component A recipients, conducting grant evaluation, and facilitating communication among all partners. PHIG is unusual in including this multi-partner support within the same funding mechanism as the group those national partners will serve (ie, component A recipients). This design accelerated the implementation of component B (eg, by the end of year 1, over 200 T/TA requests had already been made to, and addressed by, these partners). Being within one Notice of Funding Opportunity (NOFO) and program also supports coordination and collaboration both within CDC and among component A and B recipients (eg, the national partners share reporting and other timelines with component A recipients and work with the same CDC team).

CDC also embedded flexibility and streamlined requirements in component B recipients' strategies, giving them greater choices to support the wide variety of needs anticipated of component A recipients and to adapt quickly as implementation unfolds. In the large funding amount and flexibility provided to component B recipients, CDC sought to strengthen public health partnerships nationally by empowering those national partners to play a larger service role in this grant than often is possible. It also moves CDC away from being both primary

steward of the funding and primary T/TA provider; under PHIG, the T/TA role is shared. The goal is to strengthen partnerships among these national public health partners, their numerous sub-recipients, and the health departments so that those partnerships can thrive outside the grant confines. Examples of work conducted by the national partners, from regional and national grantee convening to training and evaluation planning, can be found at their website, phinrastructure.org.¹⁵ The site also highlights success stories from health department recipients across the 3 strategies under component A.

Discussion

It is worth reflecting on what PHIG could have looked like if CDC had adopted design features typical of many of its legacy funding mechanisms. The NOFO could have been focused on workforce alone, in line with the original authorizing language of ARPA, rather than embedded within a larger framework of public health infrastructure and alongside other foundational public health organizational investments. The funding could have been awarded with more requirements attached, with many specific strategies to deploy, steps to complete, and other tasks, rather than offering maximal flexibility. The recipient base could have included mainly states, with hopes that the benefits trickle down to local entities, rather than to the broader funding base PHIG has. Support for implementation and T/TA could have been funded through multiple other grants or contracts that had to be developed or adapted for this purpose, or not funded at all, with CDC trying to fill that gap.

Instead, CDC used the historic opportunity born from the challenges of the COVID-19 response and provided by Congress through ARPA to create a grant that more fully prioritizes public health departments' own needs and provides them more direct control, in hopes of accelerating change and strengthening services. For both recipients and CDC, the grant may serve as a strong model for future funding and represent an efficient means of awarding future federal funding for public health workforce and infrastructure to state, local, and territorial health departments.

Expectations for PHIG as both a potential model for funding and as a means for uplifting the governmental public health workforce and infrastructure are justifiably high. However, they need to be tempered with realism. Implementation has just begun, and the extent of transformation, achievements, and challenges to come is unknown. PHIG is only a 5-year grant seeking to address workforce and infrastructure weaknesses that began decades before through a complex set of causes.^{16–18} We also need to recognize that investments in governmental public health address only a part of the larger public health system in the United States, which involves nonprofit, academic, and other nongovernmental partners. Although the funding amount is substantial, it falls short of what others have estimated that just state and local health departments need to provide a core package of comprehensive public health services in their communities, at approximately \$4.5 billion annually.¹⁹ Moreover, substantial resources are being invested in grant evaluation through component B, but implementation and evaluation might occur too slowly or encounter challenges that hinder CDC and its partners from assessing success and (if warranted) making a strong case for continuation in time to sustain the investments made. For example, longstanding policy and system barriers to hiring staff rapidly cannot be alleviated by a financial infusion

alone. Also, PHIG's flexibility represents an added challenge for program evaluation; when the programs being evaluated are so disparate, typical evaluation approaches need to be adapted.²⁰ Other potential risks include new public health challenges such as new outbreaks or other emergencies that could derail plans for more fundamental transformation. Success also relies on CDC and its partners committing significant energy to ongoing change after the COVID-19 pandemic, a period that exhausted the best of governmental public health leadership and staff.^{21,22}

On the other hand, PHIG is not operating in isolation. Major new programs for the US public health workforce were initiated or expanded during this period. Examples include the initiation of Public Health AmeriCorps, which, with one-time ARPA funding, is providing a new pathway to public health careers to address the needs of local communities.²³ The Health Resources and Services Administration was able to make new investments in training community health workers and the rural and tribal public health workforce.^{24,25} Notably, CDC, as an integral part of the governmental public health infrastructure, also embarked on organizational and workforce changes intended to help it be more nimble and effective for future outbreaks and national priorities.²⁶ As part of that, CDC launched an enterprise-wide effort to revise its approach to funding recipients, drawing lessons from PHIG and other experiences and data. CDC can still embed some of the features of PHIG into future funding opportunities, regardless of future funding levels, although the power of PHIG rests on the size of the investment as much as the features outlined above.

The risks of not investing more in the public health workforce are high. Evidence of the need to strengthen the public health workforce had been building for years.^{27–29} A recent analysis reported high levels of separation from governmental public health before and during the pandemic, indicating that without additional support, the public health workforce might weaken further.³⁰ The objective of PHIG and similar efforts is not only to prevent further loss or weakening but also to actively strengthen the governmental public health workforce. Recognizing the invaluable role that this workforce plays in public health and the need to support its growth and development is imperative at this juncture. The approach used in PHIG is a step in the right direction toward building a public health workforce that can support the public health infrastructure needed to help safeguard the well-being of our communities.

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Implications for Practice & Policy

- Recent evidence and the COVID-19 pandemic experience highlight the needs to strengthen both the public health workforce and the broader public health infrastructure across the United States.
- The Centers for Disease Control and Prevention (CDC) is an important source of financial support to the governmental public health workforce and system, and how it designs its funding opportunities matters to how effectively and efficiently that funding can be used to benefit communities across the United States.
- The Public Health Infrastructure Grant (PHIG) combines historic levels of financial and technical support, afforded by the American Rescue Plan Act, with features used successfully in prior funding mechanisms, to offer recipients and CDC an important new tool to efficiently and effectively support the public health workforce and infrastructure across the United States.
- Although the design and initiation of PHIG are promising, monitoring and evaluating work conducted with PHIG are crucial to determining the extent to which PHIG should be sustained.

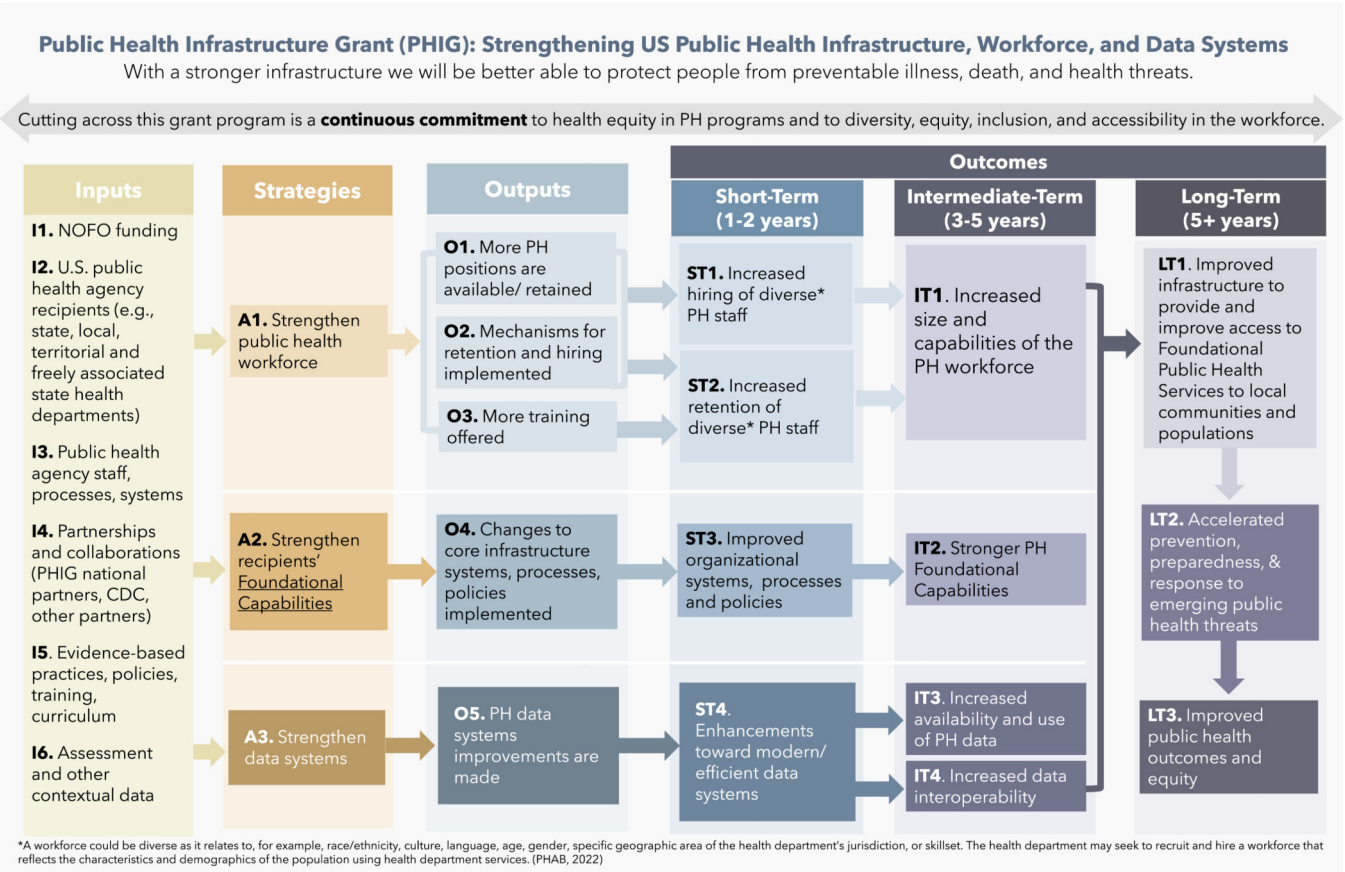


FIGURE 1.
Simplified Logic Model for OT22–2203: Strengthening Public Health Infrastructure, Workforce, and Data Systems

Grant Overview for OT22–2203: Strengthening Public Health Infrastructure, Workforce, and Data Systems

TABLE 1

Feature	Grant Component A Public Health Departments	Grant Component B National Partners
Strategy areas	• Workforce (A1) • Foundational capabilities (A2) • Data modernization (A3)	• Technical assistance and training to component A recipients for A1, A2, and A3 strategies • Evaluation of components A and B • Coordination and communication among all component A and B recipients
Recipients	Workforce and foundational capabilities • 107 Health departments, with 50 states, 49 local, 8 territories • Data modernization • 64 of the above (50 of which are state health department recipients)	Three national partners, each with multiple sub-partners • Association of State and Territorial Health Officials (ASTHO) • National Network of Public Health Institutes (NNPHI) • Public Health Accreditation Board (PHAB)
Year 1 funding per recipient as of November 1, 2023 ^a	Total awarded: \$3 685 000 000 Workforce: • Median: \$16 322 361 • Min: \$2 726 921 • Max: \$141 433 002 Foundational capabilities: • Median: \$822 876 • Min: \$259 405 • Max: \$6 008 153 Data modernization: • Median: \$2 543 798 • Min: \$1 203 439 • Max: \$42 546 853	Total awarded: \$155 000 000 • ASTHO: Communication and coordination, training, and technical assistance • NNPHI: Evaluation, training, and technical assistance • PHAB: Evaluation, training, and technical assistance
Year 1 funding, sources	ARPA multiyear funding (available through 2027): \$3 505 000 000 • Workforce: \$3 000 000 000 • Data modernization \$505 000 000 • CDC annual appropriation \$180 000 000: • Foundational capabilities: \$140 000 000 • Data modernization: \$40 000 000	ARPA multiyear funding (available through 2027): \$135 000 000 • Workforce: \$45 000 000 • Data modernization: \$90 000 000 • CDC annual appropriation \$20 000 000

Abbreviations: ARPA, American Rescue Plan Act, CDC, Centers for Disease Control and Prevention; PHIG, Public Health Infrastructure Grant.

^aThe full period of performance for PHIG is 5 years, through 2027. For a more detailed funding breakdown, please see: <https://www.cdc.gov/infrastructure/phig/state-profiles/funding.htm>

TABLE 2

Demonstrating the Infrastructure Focus and Flexibility of OT22–2203: Strengthening Public Health Infrastructure, Workforce, and Data Systems: Summaries of Year 1 Work Plans (November 2022–October 2023) From 4 Randomly Selected Recipients

City Recipient Example: Milwaukee, Wisconsin	County Recipient Example: Wake County, North Carolina	Territory Recipient Example: US Virgin Islands	State Recipient Example: Connecticut
Workforce (Strategy A1)			
Recruit and hire • Hire a Director of Public Health Workforce Infrastructure and an evaluator (PHIG requirements) • Expand staff recruitment efforts • Hire a research and policy coordinator, a grants manager, a clinic operations director, and a population health service fellow • Revise job pay scales • Create new leadership tracks Retain • Establish a staff retention and engagement fund to host staff retreats, expand employee well-being programs, and training opportunities • Retain 3 public health strategists, 2 data and evaluator coordinators, and a graphic designer on other grant funding • Cover part of the salaries for 3 public health nurses and an office assistant Sustain and support • Establish fund to help subsidize work transportation costs for health department staff • Establish a staff recognition initiative	Recruit and hire • Hire a workforce development coordinator and an evaluator (PHIG requirements) • Increase advertising for all public health postings and strengthen connections with local workforce boards • Integrate community health workers into regional centers Sustain and support staff • Strengthen mental health services available to staff by hiring additional counselors • Enhance staff recognition including holding a public health community day • Support community and team building activities for staff Train staff • Identify additional training needs of the existing workforce • Establish learning days for staff • Offer and support completion of diversity, equity, and inclusion training • Offer Spanish-language training for staff in health care positions	Recruit and hire • Hire a workforce development coordinator and evaluation lead (PHIG requirements) • Hire a data modernization director and support staff • Hire 2 clinical staff for agency health care location • Create a job description for a process improvement director; recruit and fill that role • Transition existing program manager and fiscal coordinator from one funding source to being funded by this grant • Hire environmental health officers to enhance surveillance capacity • Support full-time labor relation staff person	Recruit and hire • Hire a workforce development coordinator and an evaluator (PHIG requirements) • Hire a data modernization director and supporting staff • Hire additional administrative and grant services staff • Develop awareness and marketing campaigns for public health careers, including more outreach to more academic institutions statewide • Hire a program coordinator to partner with academic institutions to identify and expand opportunities for experiential learning • Develop an implementation plan for bringing public sector compensation in line with private sector compensation, particularly for clinical staff Sustain and support staff • Hire an internal operations manager • Inventory and review employee wellness and support programs within agency and compare with those offered to public health workers in other states • Develop and implement a Total Worker Health program • Synthesize existing data on health, well-being, and satisfaction of state public health workforce • Establish a method for routine assessment of public health staff health, well-being, and job satisfaction at state, local, and nonprofit sectors Train staff • Hire a full-time training development manager • Work with institutions of higher education with public health degree programs to review and update instructional content and develop new programs for public health training within the community college system • Create and launch a pathway program into public health careers from the community college system Strengthen workforce planning, systems, processes, and policies • Hire a data analyst dedicated to workforce analytics • Develop a plan for more systematic collection and analysis of state public health workforce and workforce development data • Strengthen and host meetings of an advisory board for public health strategy and workforce development

Foundational Capabilities (Strategy A2)

City Recipient Example: Milwaukee, Wisconsin	County Recipient Example: Wake County, North Carolina	Territory Recipient Example: US Virgin Islands	State Recipient Example: Connecticut
Accountability, performance management, and accreditation • Procure a Human Resources Performance Management System to support the implementation of agency human resource goals Organizational administrative competencies • Upgrade electronic health record system for health department's clinics • Strengthen the use of health department clinic data through the establishment of dashboards • Procure a new budgeting tool to support greater prioritization and transparency in planning and spending Community partnerships • Renew space sharing agreement with local school of public health • Create a program for college and graduate students to do internships or projects with city health department • Establish adjunct faculty roles with the local school of public health to strengthen association with health department	Community partnerships • Hire program coordinators for health equity and community health workers • Establish and strengthen partnerships with community partners with a focus on health equity Communications • Strengthen information materials to be more culturally and linguistically appropriate	Accountability, performance management, and accreditation • Strengthen employee performance planning system to include 360°, bidirectional, and other performance evaluation methods • Identify and adopt new workforce competencies for public health, diversity, and administrative professionals Organizational administrative competencies • Upgrade human resource information system, including new hardware, software, and enhanced interoperability • Upgrade financial management systems for greater efficiency • Procure software that facilitates access to electronic health information to better characterize health outcomes Communication • Identify gaps in capacity to apply for grants Policy development and legal services • Assess existing public health policies' impact on Social Determinants of Health to generate recommendations for health equity policy decision making • Train staff on existing public health policies and how to make evidence-based recommendations Community partnerships • Lead a collaborative process to conduct a comprehensive territory-wide public health needs assessment to better guide community health improvement plan updates Equity, leaderships, governance, and strategic planning • Support coordination of health equity programming to identify resources and gaps • Train staff on health equity and public health practice and programs	Accountability, performance management, and accreditation • Review existing national and state-based standards and recommendations for continuing education of the public health workforce • Renew contract with regional training center to support a public health professional training academy • Identify training needs in local health departments across the state • Support costs of CDC TRAIN subscriptions and digital libraries Organizational administrative competencies • Hire 2 process improvement specialists • Review existing state public health agency and other agencies' policies and procedures for recruitment, hiring, and onboarding of staff positions to identify opportunities for strengthening Policy development and legal services • Review licensure and statutory requirements governing the delivery of public health services in the state and disseminate findings to key partners and agencies Community partnerships • Provide support for recruitment and marketing campaigns for public health careers • Establish an environmental health fellowship program • Hire a coordinator to work with housing partners and state health equity offices Equity, leaderships, governance, and strategic planning Strengthen leadership training to better address equity and diversity

Abbreviations: CDC, Centers for Disease Control and Prevention; PHIG, Public Health Infrastructure Grant.