Public Health Nursing
Leadership, Responsibilities and Issues in State Health Departments

Results of an Association of State and Territorial Directors of Nursing (ASTDN) Survey

by

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Executive Summary

The Association of State and Territorial Directors of Nursing (ASTDN) is a professional association of public health nursing leaders in state health departments and the access point to public health nurses in each state. In an effort to assess current responsibilities of the directors (or other titles) and public health nursing issues in each state, ASTDN commissioned this study. The work was supported by the Association of State and Territorial Health Officials and CDC Public Health Practice Program Office, Workforce Development Office.

A 14-item survey was sent to the ASTDN membership in spring 2003 with a 65% response rate and a membership focus group was conducted at the annual meeting in May 2003 to discuss the findings. Notable findings are presented here and, where possible, compared to findings from a similar study done by one of the authors (Stevens) in 1991.

- Public health nurse leaders are aging. In 2003, the average number of years the ASTDN representatives had been involved in nursing was 30.8 years with a range of 20 years to 43 years
- The highest education degrees obtained by the ASTDN representatives were BSN (12%), other bachelor's (6%), master's in nursing (30%), other master's (39%) and doctorate (12%).
- The top public health nurses' titles and job descriptions were less uniform than they were in 1991, (an increase from 8 different titles to 15 titles in 2003).
- Among the reporting hierarchy of the state health departments, fewer of the top public health nurses report directly to the top public health official in 2003 (22%) than in 1991 (32%).
- In 2003, sixty-six percent of top public health nurses had general public health responsibilities.
- There were public health nursing shortages reported in 75% of states.
- Sixty-seven percent of public health nurse leaders have been active members of state bioterrorism planning teams from the beginning.

Public health nurses currently reported roles/duties/responsibilities in each of the core public health areas of assessment, policy development, assurance and leadership.

The focus group members recommended that ASTDN act to

1. Develop uniform job descriptions for public health nurse functions.
2. Clarify ASTDN membership criteria.
3. Strengthen partnerships with ASTHO, CDC, HRSA and others
4. Continue to provide national leadership for public health nurses.

Introduction

Of the estimated 448,254 members of the public health workforce, 49,232 (10.9%) are public health nurses.[1] Thus, they are the largest segment of the public health workforce.[2] State structures influence the organization of public health nursing services, but issues are similar in all the states. The Association of State and Territorial Nurse Directors (ASTDN), an affiliate of the Association of State and Territorial Health Officials (ASTHO) provides national leadership for this discipline. ASTDN has been active since 1935 in advancing the leadership role of public health nurses in protecting and promoting the health of the public.[3]

In 1995, Stevens reported in *Public Health Nursing* on the status of public health nursing directors in state health departments across the United States, identifying numerous common issues.[4] ASTDN used the results along with other data to develop an agenda for progress. More recently, the much-publicized need for public health preparedness suggested to the leadership of ASTDN, ASTHO, and the Public Health Practice Program Office (PHPPO) of the Centers for Disease Control and Prevention the need for an updated status report. ASTDN used the study design of Stevens plus additional survey questions to seek information from each state on public health nursing and public health nursing leadership. ASTHO and PHPPO provided funding, and the work was carried out by The North Carolina Institute for Public Health of the University of North Carolina School of Public Health.

Some concerns from 1995 continued in this 2003 study plus new areas of interest were identified. Issues of the location of the public health nursing leadership within the state public health structure, voice in policy regarding workforce issues, difference in roles and preparation of the state public health leader and opportunity for interdisciplinary activities were discussed in both studies.

This report summarizes the findings and also includes information from focus groups held in May 2003 to discuss the preliminary findings.

Methods

ASTDN used a 14-item survey to obtain information on public health nursing in the United States (Appendix A). Between March 2003 and June 2003, electronic and paper copies of the survey were sent to the leadership of the state departments of health in all 50 states, 5 territories, and the District of Columbia. The survey was addressed to a designated ASTDN representative and to a state health official. Completed surveys were returned via email, mail or fax. The quantitative and qualitative data were reviewed for missing and ambiguous responses, and additional contacts were made to clarify responses when necessary. Follow-up contacts to states delinquent in submitting surveys were made by ASTDN member states.

In addition to completing the survey, each respondent was asked to submit a copy of his/her organizational chart and job description. The organizational charts were used to identify the top public health nurse position in each state and count the number of positions between this position and the top public health official. A numeric score was assigned to each chart, with a score of 1 indicating the top public health position was one position removed from the top public health official's position and a score of 4 indicating it was four or more positions removed.

Job descriptions and performance plans were examined to determine the functions and duties of each state's top public health nurse. The job descriptions were analyzed using the list of duties and functions used in the earlier study by Stevens[5] with slight modifications (see Table 1). Based on the nature of the duty and responsibility, each identified function was then placed into one or more of the following categories: assessment, policy, assurance and leadership.

Table 1. Position duties/functions	
1. Policy involvement	10. Representation on professional organizations, committees, and/or boards
2. Consultation with local/state health departments	11. Setting direction for public health nursing
3. Quality assurance	12. Leadership
4. Creation of budgets	13. Licensure/regulation of home health
5. Interpretation of nursing practice	14. Personnel issues
6. Procedure development	15. Research
7. Workforce issues	16. Bioterrorism
8. Input into continuing education	17. Testimony/reporting to legislature
9. Direct supervision	18. Evaluation
	19. General public health functions

Where appropriate, comparisons were made to data collected by Stevens in 1991 and reported in the 1995 article in *Public Health Nursing*.[6]

During the working session of the 2003 ASTDN annual conference, focus groups were held to discuss preliminary survey results and actions that should be taken in light of the survey's findings. Each focus group was assigned a facilitator and note-taker.

Results

There was a 65% percent response rate to the survey (26/33=79% of the ASTDN dues-paying members, as of 7/01/03, for fiscal year 2002-03 completed the survey). Response rates by region were as follows: Northeast = 38%; Mid-Atlantic = 67%; Southeast = 100%; North Central = 50%; South Central = 100%; Mountain West = 63%; and Pacific West = 50%. (Appendix B contains a list of states by region.) This report does not include data from the five US territories.

The highest educational degrees reported by the ASTDN representatives were in five categories: nursing diploma, bachelor's in nursing (BSN), other bachelor's degree, master's in nursing, other master's degree, and doctorate. Twelve percent of the ASTDN representatives identified a bachelor's in nursing as the highest degree obtained. Only 6% reported a nursing diploma or other bachelor's as their highest degree. The most common degree held was a master's: 30% of respondents reported a master's in nursing, and 39% listed other master's degree as the highest degree awarded. Twelve percent reported holding doctorates.

Fifty percent of the states responding to the survey reported that over half of their public health nursing workforce had a BSN or higher degree. Only 10% of the states reported that less than a quarter of their public health nurses held a BSN or higher degree.

ASTDN representatives responding to the survey indicated their years of nursing experience in the following three categories: current position, public health nursing, and nursing. The mean number of years the ASTDN representatives had been working in their current position was 6.4 years, with a standard deviation of 4.3 years and median of 5 years. The mean number of years working in public health nursing was 21.0 years, with a standard deviation of 10.3 years and median of 24 years. The mean number of years the ASTDN representatives had been in nursing was 30.8 years, with a standard deviation of 5.6 years and a median of 31 years. These data reflect trends throughout nursing. The May 2003 U.S. Nursing Shortage Update by Fitch Ratings found that in 2000 the mean age of nurses in all sectors was 40 years old; only 32% were under the age of 40 and only 9% were under 30 years old.[7]

The job titles held by the top public health nurses were in two categories: positions having "nurse" or "public health nurse" in the title and positions containing a general public health title. The titles used in 1991 and 2003 are shown in Table 2. In both 1991 and 2003, the titles "Director of Public Health Nursing" or "Public Health Nursing Chief" were held by 48% of respondents. The number of positions with the title "State Director of Nursing" or "Chief Nurse" decreased by 9% from 1991 to 2003 and the number of positions with the title "Director of Community Health Nursing" shrank by 12% over the same period. Between 1991 and 2003 the variety in the position titles held by top public health nurses increased. In 1991, there were 8 different position titles, but by 2003 the number of position titles held by the top public health nurses had expanded to 15.

States submitting data in both 1991 and in 2003 (n=18) showed a similar pattern—there were fewer top nursing position titles containing the word(s) "public health nurse" or "nurse" in 2003 than in 1991. Half of the states' top public health nurse titles remained the same in 2003 as in 1991, and all of these contained the word(s) "public health nurse" or "nurse." Of the states in which titles changed, 33% of position titles moved from including public health nurse" or "nurse" to general public health titles, while 44% changed titles but retained the word(s) "public health nurse"

or nurse" and 22% which were originally general pubic health titles continued to be general with slight alterations.

Table 2. ASTDN Representatives' Position Titles

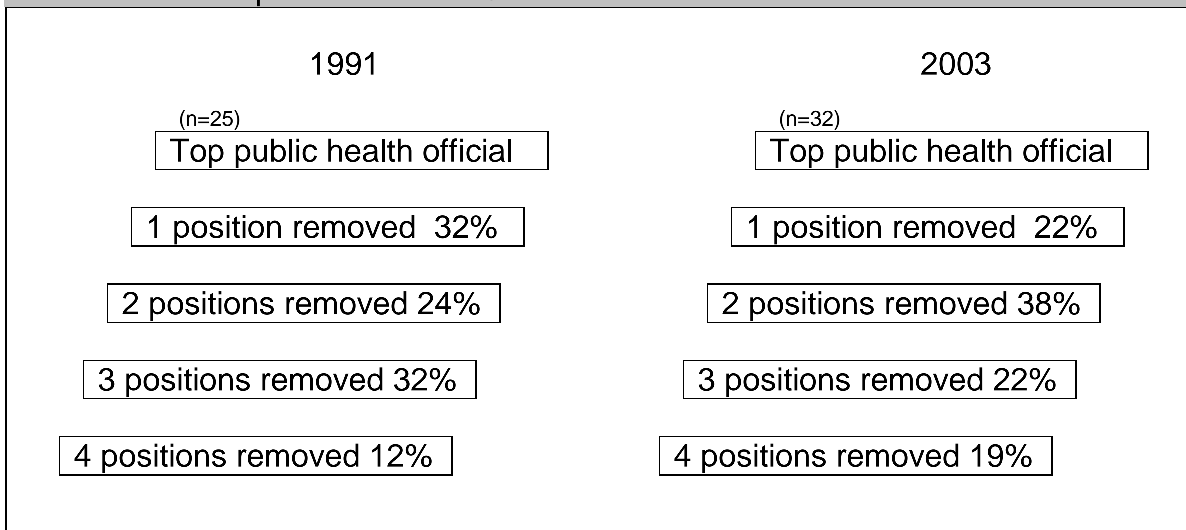
	1991 (n=25)	2003 (n=33)	1991 *data for states submitting data for 1991 and 2003* (n=18)	2003 *data for states submitting data for 1991 and 2003* (n=18)
	%	**%**	**%**	**%**
Position title contains "nurse" or "public health nurse"	76	67	89	72
Position titles were general public health	24	33	11	28
Position titles contain "nurse" or "public health nurse"				
Director of Public Health Nursing	28	30	39	33
Public Health Nursing Chief	20	18	22	17
Chief Nurse/State Director of Nursing	12	3	16	11
Director/Chief of Community Health Nursing	12	-	11	-
Public Health Nurse Consultant	4	3	-	-
Manager II of Public Health Nursing	-	3	-	-
Public Health Nursing Coordinator/Liaison	-	9	-	11
Position with general public health titles				
Director/Chief of Community/Local Health Services	16	9	6	-
Director of Division of Maternal and Child Health	-	3	-	6
Deputy State Health Officer	-	3	-	6
Deputy Secretary of Health	-	3	-	6
Deputy Administrator	-	3	-	-
Manager of Office of Community Liaison	-	3	-	6
Public Health Program Manager/Chief	4	3	-	-
Regional Patient Care Leader	-	3	-	-
Health Management System Administrator	-	3	-	6
Field Services Manager	4	-	6	-

Percentage totals may be greater than or less than 100% due to rounding.

All of the state public health organizational charts submitted in 2003 had been updated within the past 3 years: 52% had been updated in 2003, 38% had been updated in 2002, and 10% had been last updated in 2001.

According to the organizational charts submitted in 2003, over half of the persons responsible for state public health nursing now report directly to or are two organizational positions removed from the top public health official. The remaining 41% are three or more positions removed from the top public health official. Comparison of the organizational charts submitted for Stevens' 1991 study and the 2003 organizational chart data (Figure 1) shows an overall decline in the number of public health nurses reporting directly to the state's top public health official, but an increase in the number of public health nurses located only two organizational positions down from the top public health official. However, since among the 32 organizational charts submitted in 2003 only 17 had provided organizational chart information in 1991, it is not clear whether the percentage of individuals located two positions away from the top public health official increased as a result of organizational change or whether the percentage increased simply because different states were reporting in 2003. Nevertheless, comparison of the organizational charts of the 17 states that submitted them in both 1991 and 2003 and all the state organizational charts submitted in 2003 shows a similar trend, with an increase in the percentages of state public health nurse positions two and four positions removed from the top public health official (Figures 2 & 3). Twenty-nine percent of the states saw a decrease in the number of positions by which the top public health nurse was removed from the top public health position, 35% saw an increase, and 35% remained unchanged. Among the states in which the top public health nurse position was moved further from the top public health official, 50% moved from being one position away to being two positions away. Of the states in which the top public health nurse position moved towards the top public health position, 40% reported moving to within one position below the top public health position on the organizational chart.

Figure 1. The Organizational Relationship of the Top State Public Health Nurse to the Top Public Health Official



Percentages may be greater than or less than 100% due to rounding

Figure 2. Percentage Change in Number of Positions Removed From Top Public Health Official in 1991

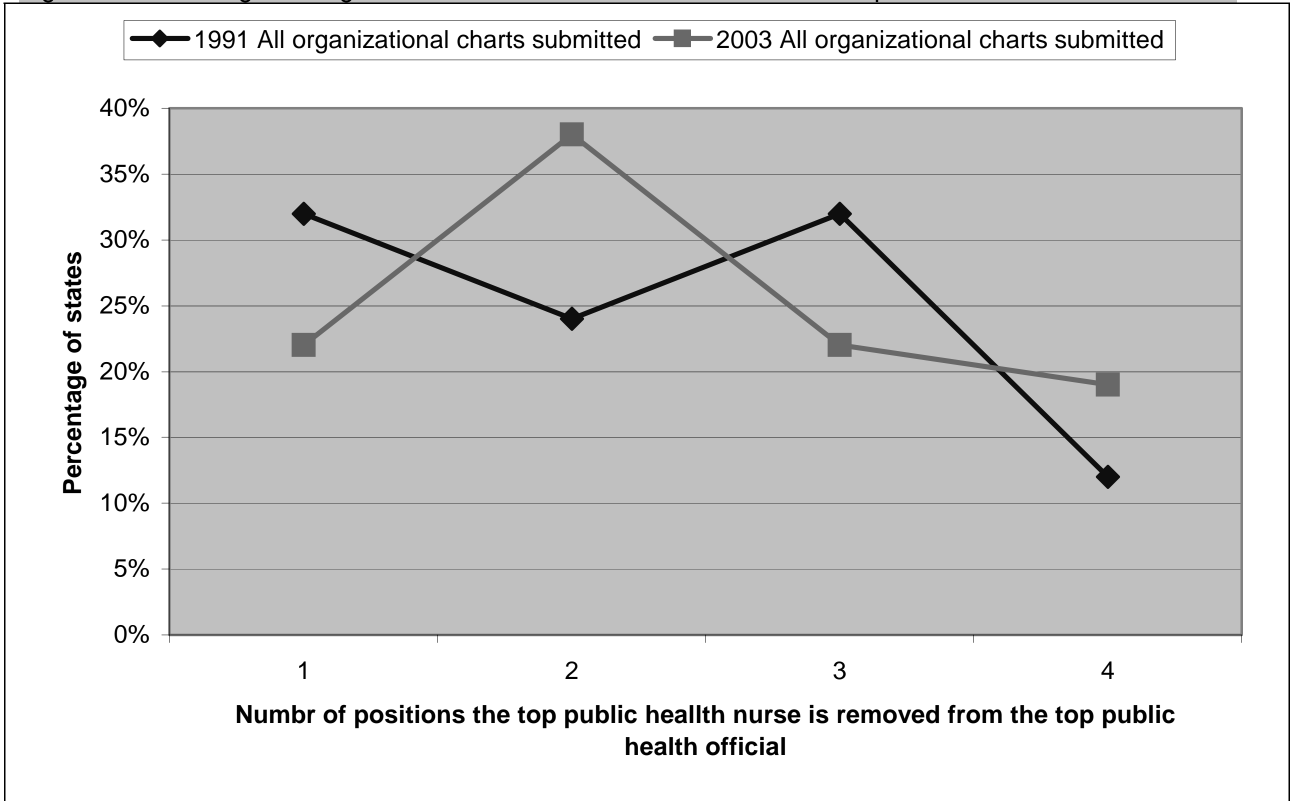
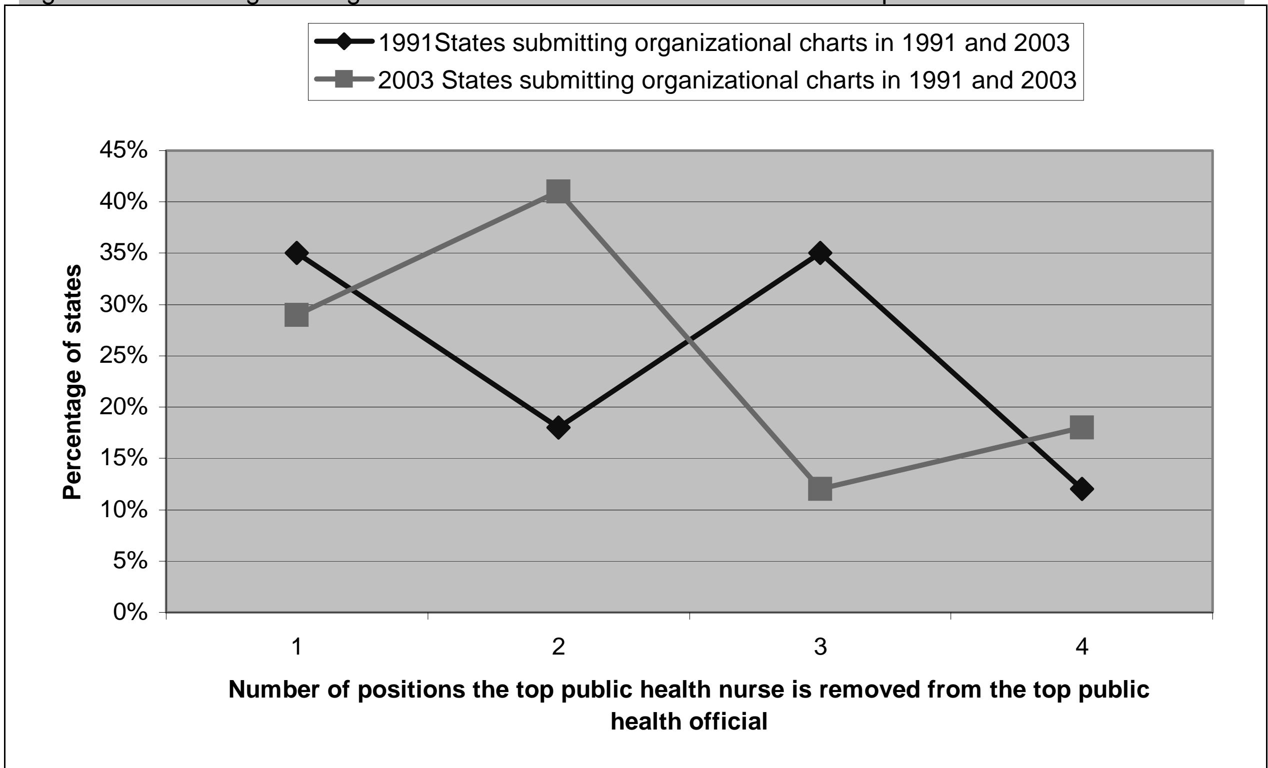


Figure 3. Percentage Change in Number of Positions Removed From Top Public Health Official in 2003



Areas of responsibility and duties for the top public health nurses varied, but the majority of roles fit into one of more of the core public health functions of assessment, policy, assurance and leadership (Table 4). Comparison with the 1991 study results showed that the top public health nurse's roles and responsibilities increased in certain areas and decreased in others. Notably, the percentage of top public health nurses involved in policy decreased, from 81% to 72%, though the percentage of those involved only in public health nursing policy increased from 46% to 59%. The percentage of top public health nurses directly involved with budget creation or budget development decreased from 54% to 38% from 1991 to 2003.

In addition to nursing-specific responsibilities, 66% of the job descriptions submitted contained functions that are considered general public health duties. These duties included supervising non-nursing personnel, managing public health issues that cut across departmental programs, collaborating with third party payment programs and directing other components of an agency.

Four states chose not to submit job descriptions for the 2003 study. The reasons given included recent reorganizations, changing performance expectations and the absence of written job descriptions. Finally, one state reported that the top public health nursing responsibilities for the state had been divided among multiple senior level nurses in that state and no one nurse's job description encompassed all the functions carried out by the group.

Table 4. Top Public Health Nurse Roles/Duties/Responsibilities	*1991 Study results %	2003 (n=29) %
Assessment		
1. Consultation with local/state health departments	81	69
2. Workforce issues	61	72
3. Role in continuing education programs	61	48
† 4. Testimony/reporting to legislature	-	38
† 5. General public health role	-	66
Policy		
1. Involved in policy	81	72
Only public health nursing policy	46	59
2. Representation in professional organizations, committees and boards (not including ASDTN)	73	79
3. Procedure development	65	48
† 4. Personnel issues	-	72
† 5. Testimony/reporting to legislature	-	38
† 6. General public health role	-	66
Assurance		
1. Quality assurance	73	52
2. Interpretation of nursing practice	73	72
3. Creation of budget	54	38
4. Leadership	46	62
5. Licensure/regulations of home health	23	4
6. Research	19	10
7. Evaluation	-	59
† 8. General public health role	-	66
Leadership		
1. Setting direction for public health nursing	65	69
2. Direct supervision	58	86
† 3. Personnel issues	-	72
4. Bioterrorism	-	24

* Percentages are results from ASTDN mailed survey administered 1991, "-" indicates that data were not collected on that role.

† Testimony/reporting to legislature, Personnel issues, and General public health role appear in multiple categories

The ASTDN representatives were asked to identify the organizational structure of public health in their states. Thirty-three percent of the states reported that they were centralized, with local staff being hired by the state system and local agencies controlled by the state. A decentralized state public health structure, with local public health staff hired locally and autonomous local agencies, was reported by 46% of the states. A mixed authority or shared structure was reported by 21%.

Of the states that self-identified as having a centralized public health organizational structure, 81% said that the ASTDN representative had non-nurse staff reporting directly to him/her. Seventy-three percent of the states with decentralized structures

said that non-nurse staff reported directly to the ASDTN representative, and 71% of the states with shared or mixed authority indicated that the ASTDN representative directly supervised non-nursing staff. These percentages indicate that the majority of ASTDN representatives are responsible for personnel other than nurses. However, it is important to note that 76% of the representatives indicating they supervised non-nursing staff supervised three or fewer non-nursing personnel. With the data collected, it was not possible to identify the various types of non-nursing personnel (e.g. administrative, other public health professionals) that ASTDN representatives directly supervised.

The great majority (94%) of the states responding indicated that a Blue Ribbon Panel, Statewide Advisory Committee, Center for Nursing or other entity had been formed to develop strategies for abating the nursing shortage, and 82% of the states reported that public health nursing was represented on these panels or committees. In 62% of the states, the ASTDN representative was a part of this group. Eighteen percent of the states reported having a panel or committee on which public health nursing was not represented.

Two thirds (67%) of the ASTDN representatives responding reported involvement in bioterrorism planning from the beginning; only 3% were not involved at all (Table 5).

Table 5. Public health nurse participation in state bioterrorism planning

	*%of States (n=33)
Involved actively from the beginning	67
Involved since the state began working on its smallpox plan	21
Involved since plans were specific to PHN administering the smallpox vaccine	18
Involved as a consultant but not directly participating	9
Not involved	3
Other	9

*Percentages sum to more than 100% because respondents could select more than one category

Sixty-nine percent of the ASTDN representatives responding reported having direct responsibility for an annual budget; 31% claimed to have no budgetary responsibility. The estimated annual budget amounts the ASTDN representatives were responsible for ranged from $15,000 to over $230,000,000.

In 68% of the states returning the survey, public health nurses had a salary increase since 2000. A further breakdown showed that only 11% of the states' public health nurses received a salary increase in 2003; 43% of the states reported that 2002 was the last year a salary increase was given. Thirty-two percent of the states reported that most recent salary increase for public health nurses were before 2000. The reports on salary increases did not differentiate between market factor, new career ladder and performance evaluation increases.

The average vacancy rates for public health nurse positions in each state are summarized in Table 6. The high rate of non-responses to the question on position vacancies might suggest a need for systematic ways to track public health nursing position vacancies at both the state and local levels. While public health nursing vacancy rates varied at both the state and local levels, almost half the states reported vacancy rates below 10%., similar to overall nursing vacancy rates in the U.S. In 2001, there was a 6% nationwide nursing vacancy rate average among all health care settings and an average vacancy rate approximately 13% for hospital nurse positions.[8]

Table 6. Average vacancy rate for vacant public health nurse positions at state and local levels and state public health structure

	State Level PHN Vacancies			Local Level PHN Vacancies		
	Centralized (n=10)	Decentralized (n=9)	Other (n=6)	Centralized (n=4)	Decentralized (n=4)	Other (n=3)
Vacancy percentage range	% of states	% of states	% of states	% of states	% of states	% of states
0 – 4.9%	20	67	33	-	50	-
5.0% -9.9%	20	11	17	25	25	33
10.0% - 14.9%	10	11	33	-	25	66
15.0% - 19.9%	30	11	17	50	-	-
20.0 % - 24.9%	-	-	-	25	-	-
25.0% - 29.9%	-	-	-	-	-	-
≥ 30%	20	-	-	-	-	-
Number of states reporting unknown, unable to respond, no response, or unusable data	1	6	1	7	11	4

While 75% of the responding states quantified the public health nurse vacancy rates at the state level, county/local level or both, even more states noted factors contributing to the vacancies (Table 7). Only 7% said that recruitment of public health nurses was fairly easy. The majority cited position freezes (53%) and recruitment difficulties due to salary issues (73%) as reasons for vacancy rates. Converting positions to other types of personnel and losing unfilled positions at the end of fiscal years were identified as also contributing to current vacancies. Other reasons included difficulty recruiting in rural areas, state budget shortfalls and cutbacks, residency requirements, and vacancies in advanced practice nurse positions.

Table 7. Current Status of Vacant Positions

	% (n=30)
Position is frozen	53
Position will be lost if not filled by end of fiscal year	23
Recruitment is difficult due to salary	73
Positions are being converted to different type of personnel	27
Recruitment is fairly easy	7
Other	37

Percentages do not sum to 100% due to multiple responses per state

Focus Groups

In May 2003, at the annual ASTDN meeting in Salt Lake City, Utah, a work session was held to present and discuss the preliminary results of this study. The findings were presented and then the larger group (N= 20) was divided into three smaller cohorts to participate in focus groups lasting 45 minutes. A facilitator (ASTDN President, President-Elect, and Past President) and note taker were assigned to each focus group. The study staff (R. Stevens and A. Brown) and an ASTHO representative (T. Stephens) were also available for questions.

The focus groups contained 6 to 8 participants and each group included members from centralized, decentralized and mixed states. The goal of the focus group discussions were to react to the report; and use the report as a basis for developing ideas leading to concrete and accomplishable action steps. The following questions and issues were discussed:

1. React to the data/report and identify opportunities as well as threats for ASTDN (maybe limit to 2 each).
2. What could/should be ASTDN's actions regarding the opportunities/threats?
3. How could partners participate?
4. Are there certain roles/functions that the public health nursing directors (or title of lead PHN) must keep?

Focus Group Results

The focus groups identified several opportunities for ASTDN, ranging from activities unique to ASTDN, such as creating model job descriptions for ASTDN members, to activities that could benefit public health nursing in general, such as public health nursing research. The following lists include the items discussed during the focus group meetings. Some of the items will require collaboration with partners while others should be done by the ASTDN membership.

ASTDN Membership:

1. Develop a model job description for public health nurse executives with critical functions, scope and standards identified.
2. Re-conceptualize public health nursing as a central component of the public health infrastructure and include in all grants, etc.
3. Develop productivity standards based on public health nursing competencies.
4. Continue to pursue certification for public health nursing.
5. Develop a standard data set and keep it updated (every 2 years).
6. Set priorities based on these results.

Collaboration/partnership with others:

1. Define a realistic role for public health nursing.
2. Recognize the shortage and graying of public health nurses.
3. Enhance interactions with ASTHO.
4. Disseminate the findings about public health nursing.

Threats identified:

1. Decline in the numbers of public health nurses.
2. Decline in the responsibilities of the chief (director) of public health nursing.
3. Distancing of public health nursing leadership from the top public health official.
4. Views that public health nurses are not interdisciplinary.

ASTDN's possible actions:

1. Encourage all states to provide data for this survey.
2. Develop model job description with scope, standards and qualifications.
3. Encourage participation in ASTDN.
4. Be more active in workforce development.
5. Keep retention and recruitment and vacancy data consistent across states.
6. Encourage public health nurses to work as part of broader public health teams.
7. Expand the partnership with ASTHO.
8. Expand other partnerships.
9. Measure the preparedness of public health nursing.
10. Realistically plan for the future of public health nursing and the shortage.

Roles:

1. Planning
2. Advising
3. Resources

Enhanced partnerships:

1. Partnerships are needed within state health departments and federal partnerships with HRSA, CDC, ASTHO, NACCHO and others should be decided on.
2. QUAD Council
3. NLN
4. National Boards of Nursing.

Essential roles/functions for public health nurse leaders to keep:

1. Professional practice leader (legal requirement)
2. Workforce issues
3. Budget/policy
4. Setting direction for public health nursing.

Similar messages and themes were heard from each of the four sub groups. These were:

1. Public health nursing is essential for public health practice.
2. Top nursing leadership is needed in each state and the public health nursing leadership should be part of the state leadership team.
3. ASTDN needs ASTHO's support and partnership.
4. ASTDN is a major national spokes group for public health nursing leadership and practice.

Summary

An external criticism often heard, but not specifically referenced or documented, reflects the perception that public health nurse leaders are not "team oriented" and focus only on nursing. A review of the job responsibilities of the leaders reveals that the reality is different than the perception. Nevertheless, there is a paradox around public health nursing. The interdisciplinary approach of public health requires that nurses be dispersed as team members in the public health workforce instead of being grouped by discipline. However, some public health clinical and prevention services require a group of nurses to be together to deliver these services and these assignments need a different type of leadership and infrastructure. These are issues that ASTDN should consider and make recommendations on.

ASTDN Recommendations:

Based on the results of this national survey and the follow up focus group of public health nursing leaders from state health departments, several specific recommendations are identified. As public health nursing is the largest segment of the public health workforce it is critical that these recommendations be addressed to assure the continued viability of our public health infrastructure. Key overall recommendations are as follows:

1. Develop a model job description for public health nursing leaders, which could be adopted by State Health Officials. Job description will reflect the key roles and responsibilities reflected in exemplary documents from several states and incorporate the public health nursing leadership role as described in *"Public Health Nursing, a Partner for Healthy Populations"* and "*Public Health Nursing Leadership, a Guide to Managing the Core Functions"*. (Model job description under development with completion date of January 2004.)

2. Utilize model public health nursing leadership job description to assure this leadership role is identified in each state. (ASTDN to continue to work with state health officials and ASTHO's Workforce Development Initiative.)

3. Focus on strategies to address public health nursing shortage. This may include assuring that public health nursing leaders are active participants on their state nursing shortage task forces and continuing work with national organizations on nursing shortage and workforce development issues. (ASTDN to actively participating with the ASTHO and CDC public health workforce initiatives. Representation is already established and initial strategies are currently under development.)

4. Establish with HRSA*, Division of Health Care Professionals a more detailed data set specific to the public health nursing workforce. Also work to develop consistent and timely data collection in each state as related to retention, recruitment and vacancies. (This is a priority area of focus for the coming year working in partnership with HRSA, CDC, and ASTHO.)

5. Continue to articulate the role and educational needs of public health nursing leadership in public health policy, public health preparedness, and resource management. (This area needs further development and should involve partners at ASTHO and ACHNE.)

6. Re-survey the public health nursing leadership in 3 years, utilizing a more comprehensive survey tool. Results of this survey would serve as baseline on which to measure progress. (Revised survey tool currently under development with completion by December 2003.)

*For a list of acronyms and accompanying definitions see Appendix C.

Appendices

Appendix A. 2003 ASTDN Survey Instrument

1) Please attach a copy of the organization chart for your state showing the relationship of your position (as lead PHN for the state) to that of the Commissioner/Secretary/or other top official in your agency AND the State Health Officer (if different).

2) Please attach a copy of your current job description(s). (Several of you currently hold more than one position, with the second position being focused more on non-nursing functions, so please send all applicable.) *NOTE that if you are a designated ASTDN representative who is not in a designated top PHN position in the state – e.g., you are one of several PHN Consultants but the designated representative to ASTDN, please provide information on how the selection of an ASTDN representative occurred.*

3) If there are responsibilities on your job description that you no longer do, please mark through those with a pencil so that the original information is still legible. Likewise if there are job responsibilities on which you spend a significant amount of time that are not in your job description, please pencil those in.

4) How is public health structured in your state?
   ___ Centralized (local staff are hired by state system and local agencies controlled by state)
   ___ Decentralized (local staff are hired locally and local agencies are autonomous)
   ___ Other (e.g. shared or mixed authority) Explain. ____________________________
   ____

5) How many staff report directly to you?
   ___ Nurses
   ___ Non-nurses

6) How many PHNs are employed at the state level? ___________
   What is their relationship to your position?
   ___ Supervised by me
   ___ Organizationally linked to me but not direct reporting relationship
   ___ No relationship
   ___ Other: explain: ____

7) How many PHNs are employed at the city/county level? ____________
   What is their relationship to your position?
   ___ Supervised by me
   ___ Organizationally linked to me but not direct reporting relationship
   ___ No relationship
   ___ Other: explain: ____

8) Of the numbers of PHNs in questions 6 and 7, what is the number educationally prepared at the following levels:
____ ADN/Diploma
____ BSN or higher

9) Is there a Blue Ribbon Panel, Statewide Advisory Committee, Center for Nursing or other entity in your state that is looking at strategies for addressing the nursing shortage?
____ Yes ____ No
If yes, are you on this group? ____ Yes ____ No
If no, then is public health nursing represented? ____ Yes ____ No
When initiated?_______ Ongoing? Yes____ No____
Comments____

10) As a part of your state's planning for bioterrorism, have you been:
____ involved actively from the beginning
____ involved since your state began working on its smallpox plan
____ involved since those developing the plan realized PHNs were needed to give the smallpox vaccine
____ involved as a consultant but not directly participating
____ not involved
____ other explain: ____

11) Estimate the annual budget you are responsible for with consideration to both operational expenses and personnel expenses:
You are directly responsible for $_____________
Are there other budget decisions that you indirectly influence? (For example, projects or recommended products for purchase such as safety needles, dressings for smallpox care?)
Yes ___ No ___ Give examples:___________________________
____

12) Of the public health nurse positions in your state, what is your average rate of vacancy?
_______% vacancy at state level
_______% vacancy at local level

13) What is the current status of these vacant positions (check all that apply):
___ Positions are frozen.
___ Positions will be lost if not filled by end of fiscal year.
___ Recruitment is difficult due to salary.
___ Recruitment is difficult for other reasons.
___ Positions are being converted to different type personnel (e.g. health educator, social worker).
___ Recruitment is fairly easy; positions will not be vacant long.
___ Other (explain) ____
____

14) When was the last time public health nurses in your state had a salary increase?
(This may have been in the form of market factor increase or new career ladder or other.)
Comments ____
____

Name ______________________________________
Education Level (list degrees) ________________________________
_____ Years in current position
_____ Years in public health nursing
_____ Years in nursing

Appendix B. ASTDN Regions and Corresponding States

Region	States
Northeast:	Connecticut, Massachusetts, New Hampshire, Vermont, Rhode Island, Maine, New Jersey, New York
Mid-Atlantic:	Virginia, West Virginia, Delaware, Maryland, Pennsylvania, Washington, DC
Southeast:	Alabama, North Carolina, Georgia, South Carolina, Tennessee, Kentucky, Mississippi, Florida
North Central:	Indiana, Michigan, Wisconsin, Iowa, Kansas, Missouri, Illinois, Ohio, Nebraska, Minnesota
South Central:	Louisiana, Texas, Arkansas, Oklahoma, New Mexico
Mountain West:	Idaho, Montana, Colorado, Utah, Wyoming, Arizona, North Dakota South Dakota.
Pacific West:	Oregon, Hawaii, Alaska, California, Nevada, Washington

Appendix C. List of Acronyms

Acronym	Meaning
ACHNE	Association of Community Health Nursing Educators
ASTDN	Association of State and Territorial Directors of Nursing
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
HRSA	Health Resources and Service Administration (a part of the US Department of Health and Human Services)
NACCHO	National Association of County and City Health Officials
NLN	National League for Nursing
PHPPO	Public Health Practice Program Office (a part of the Centers for Disease Control and Prevention)
PHN	Public Health Nurse
QUAD Council	The Quad Council is a partnership of four public health nursing organizations: The Public Health Nursing Section (American Public Health Association) The Council on Nursing, Primary Care Nursing and Long Term Care (American Nurses Association) The Association of Community Health Nurse Educators The Association of State and Territorial Directors of Nursing

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