

# Practice Research Linkages: A Multi-Year Case Study of Public Health Competencies for Public Health Action

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The public health learning experience (1997-2000) with the Columbus and Franklin County (Ohio) Health Departments created the opportunity to apply the organizational and individual competency research conducted by Rollins School of Public Health of Emory University under support from the ASPH/CDC Cooperative Agreement. This multi-phase, multi-year applied research study was conducted with multiple health agency partners in different geographical areas. The results of these study phases provided the content and direction for the field-based and -developed learning initiative for all members of the Columbus and Franklin County public health agencies.

## The context of this study

1992 was the best of times and the worst of times for public health;

. . . **best** because the Institute of Medicine report on the Future of Public Health (1988) gave rise to a new awareness of the core functions of public health with its focus on health and prevention; linkages were being forged between the academic and practice communities through such initiatives as the Faculty/Agency Forum and the Council on Linkages Between Academia and Public Health Practice; capacity issues were being addressed through a self-assessment process outlined in *APEXPH* (Assessment Protocol for Excellence in Public Health); and through shared experiences in the newly initiated national public health leadership institute, early cohorts of scholars were becoming significant catalysts for change in state and local health departments—

and **worst** because public health leaders nationally were not being heard in the health care reform debates that characterized the next two years. Indeed, few outside of public health could articulate the vision, mission or role of public health—and even within public health, few were ready to challenge the status quo or climb out of the safety of their categorical disease boxes.

## Defining the future of public health

It was during this period that colleagues at the Center for Public Health Practice of the Rollins School of Public Health at Emory University began to ask focus groups of practice partners in several health districts in Georgia the following questions:

- What would make your community a healthier place to live?
- What would public health agencies be doing?
- What functions would be critical?
- What would this look like? How would you know it?
- What would public health practitioners be doing, and what behaviors describe these actions?

Explicit instructions were given—in answering these questions, *forget current job descriptions and forget current job classifications. Forget current categorical programs and funding restraints. Think about a future that you want to help create.*

From these simple questions we embarked on a journey that was to take us through the many settings in which public health is practiced and observe the many functions and behaviors in which practitioners might be engaged.

Most health department managerial personnel agreed with the assumption that public health agencies would probably need to change, but the direction and the magnitude of the change was uncertain. Thus, the future posed a challenge to public health, including the necessity of aligning the focus on population-based health with new prevention strategies and operating principles.

This realignment requires agencies to employ new perspectives, engage in rigorous strategic planning, and undergo traumatic organizational change. Meeting this challenge requires the application of innovative tools and methodologies that help agencies focus on the future, while linking lessons from the past with the “current reality.” The scope of the project’s work was soon to include both the articulation of new competency areas that our nation’s agencies may need to adopt and the equally important issue of how to incorporate these significant behavioral changes into the culture of public health.

As answers began to emerge, the data were sorted into categories or broad competency areas: visionary leadership; communication; information management; assessment, planning and evaluation; partnership and collaboration; systems thinking; promoting health; and preventing disease (See [Table 1](#)). These areas were further broken down into sub-competencies by customer setting. In other words, how visionary leadership is expressed with an individual patient will be markedly different from how it is expressed within the agency itself, and yet each is different from how it is expressed within the community. Visionary leadership is critical in each setting, but how it is expressed varies.

An instrument was then developed which allowed respondents (again, practitioners in agencies) to rank the importance of each competency and to rate and rank training needs. The instrument was field tested both in Georgia and in other states, revisions being made along the way to refine the validity and utility of the instrument.

The competency areas were broken down further by organizational level within the agency. For instance, how was visionary leadership demonstrated by senior agency management different from how it was expressed by a supervisor, or a clinician, or a technician or a clerk? This breakdown was then field-tested, and the resulting data were translated into individual performance indicators appropriate to job function and level that could be incorporated into a performance appraisal system.

### **An emphasis on application**

What made the work unique in the field was how linked it was to the practitioner. Virtually every phase of the study was conceptualized, surveyed, validated and field tested among public health practitioners. Over the next three years we would continue to validate in the field with all levels of staff within health departments those areas of organizational competence critical to advancing the public health mission.

Moving on in our journey, the Public Health Functions Steering Committee, with national public health practice partners (in 1995), elaborated the public health vision, mission, and essential public health services as a more descriptive way to present the core public health functions of assessment, policy development and assurance. Many of the ideas that we had captured in our focus group word pictures were now spelled out in terms of empowerment through education and linking people to health resources, developing constituencies and so on.

There were also several other milestones on our journey which served to confirm that we were not alone in our thinking, but moving along parallel paths. The early cohorts to participate in the public health leadership institutes sponsored by the Western Consortium with CDC support were being exposed to the latest thinking in leadership development, management theory and practice. Constructs and ideas such as those presented by Senge (*The Fifth Discipline*, 1990) and others began to energize the collective thinking of these leaders. But energized or inspired, many of these practice colleagues confided that once back in their own agencies, they usually encountered the inertia and resistance that confronts any change to the status quo.

## Tackling cultural parameters

What we had been developing was, in fact, the organizational complement to the work of the national and regional leadership institutes, and the real question we were trying to answer was: how do we create the organizational *culture* to support the essential public health services.

We talk about *education* and its components of teaching, learning and training. Is education not really the transmission of culture? *Culture* consists of those beliefs, values, norms, and knowledge that guide our actions as citizens and responsible members of society. We know that there are positive and negative aspects of culture transmitted through both formal and informal processes.

Organizations possess cultures: one needs only to walk in the door, look at eye contact, listen to the subtle nuances of voice and body language. One might be tempted to say that it is a question of size or rurality. But recently the author had the opportunity to participate in site visits to six rural counties and three urban counties in a southern state, all operating with the same mandates and level of resources per population. It was reaffirming to observe that those organizational competency areas identified and validated in our study also defined/described those critical success factors that not only supported the performance of the essential public health services but also contributed to ongoing organizational learning and continuous striving to improve performance.

## The present

In a sense, the partnership with our Columbus, Ohio practice colleagues is about the teaching/learning process to transmit a public health culture. This is education that is highly participatory, with a high ratio of process to lecture.

How would we characterize the present . . . as the best of times? the worst of times? a time of promise and potential?

Many exciting things are occurring in public health—the convergence of which promises to have a positive impact on public health as a profession, and on the health status of our communities. Some of these initiatives include:

- **Healthy People 2010 Objectives** with a focus area on infrastructure that emphasizes workforce development and information systems;
- **The National Public Health Performance Standards Program (NPHPSP)**, with state, local and governance body quality improvement tools that operationalize the essential public health services within a public health system context;
- The new generation of *APEXPH: Mobilizing for Action through Planning and Partnerships (MAPP)*, a tool which applies strategic planning principles to support the community health improvement process with multisector partners;
- The **CDC-ATSDR Strategic Plan for Workforce Development** promises to continue the direction of the report *The Public Health Workforce: An Agenda for the 21<sup>st</sup> Century* (September 1997) and to provide direction for a life long learning system for public health practitioners; and,
- HRSA- and CDC-supported initiatives to provide workforce development and training through distance learning and continuing education programs.

These initiatives and others promise to focus necessary attention on public health workforce issues.

### **Next steps**

Traditional training approaches may not be enough to institutionalize the required competencies for public health in the next decade. The educational experience must also utilize coaching, mentoring, modeling, awareness and recognition programs. This will mean reinforcing performance through job descriptions and performance evaluation that acknowledges action that demonstrates the desired culture.

The work described here has been compiled into a tool designed FOR and WITH the public health practice community. ***The Public Health Competency Handbook: Optimizing Organizational and Individual Competence for the Public's Health*** (authors: Nelson, Essien and Loudermilk) is being prepared for publication by Aspen Publishers, Inc. This “how to” guide helps to translate some of these competency issues into improved performance—both organizational and individual—for the desired outcome: improved health status and quality of life for all community members.

The study continues today and is expected to evolve, as additional observations are collected about the ways agencies and their community health partners can best adapt to the changing public health environment. Updated revisions to the *Handbook* that incorporate learning from agencies and their community health partners may be published. In all instances, what makes the outputs of this study special is that they have been conceived, tested, refined and retested among practitioners.

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