Council on Linkages Between Academia and Public Health Practice

Virtual Meeting

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Monday, July 16, 2018
12:00-2:00 pm EDT

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Registration URL:

https://attendee.gotowebinar.com/register/4542615089063009027

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Funding provided by the Centers for Disease Control and Prevention
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Staffed by the Public Health Foundation

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Activities of the Council on Linkages Between Academia and Public Health Practice (Council on Linkages) are made possible through funding from the Centers for Disease Control and Prevention under Cooperative Agreement Number U38OT000211. The content of Council on Linkages activities are solely the responsibility of the Council on Linkages and do not necessarily represent the official views of the sponsor.

1. Meeting Agenda

The Council on Linkages Between Academia and Public Health Practice

Council on Linkages Between Academia and Public Health Practice
Virtual Meeting

Date: Monday, July 16, 2018
Time: 12:00-2:00pm EDT
Register for Web Access: https://attendee.gotowebinar.com/register/4542615089063009027

AGENDA

Time	Item	Presenter
12:00-12:05	Welcome and Overview of Agenda	*Bill Keck*
12:05-12:10	Approval of Minutes from December 12, 2017 Meeting ➢ **Action Item**: Vote on Approval of Minutes	*Bill Keck*
12:10-1:00	State of the Council: Where We've Been, Where We Are, Where We're Headed (Council Strategic Directions – A.1.b., A.1.c., C.1.e.)	*Bill Keck, Ron Bialek*
1:00-1:30	Core Competencies for Public Health Professionals (Council Strategic Directions – B.1.b., B.1.e., C.3.a., C.3.b., C.3.c., C.3.d.) ➢ Core Competencies Use ➢ Healthy People 2030 ➢ New Competencies Released:	*Amy Lee, Janet Place*
	o Competencies for Performance Improvement Professionals in Public Health	*Kathleen Amos*
	o Quad Council Coalition's 2018 Community/Public Health Nursing Competencies	*Susan Little*
1:30-1:50	Academic Health Department Learning Community (Council Strategic Directions – A.1.a., A.1.b., A.1.d, A.2.b.) ➢ AHD Webinar Series and Ask the AHD Expert Column ➢ Staged Model of AHD Development ➢ AHD Mentorship Program	*Bill Keck*
1:50-2:00	Other Business and Next Steps	*Bill Keck*
2:00	Adjourn	

2. Council Member List

Council on Linkages Members

Council Chair:

C. William Keck, MD, MPH
American Public Health Association

Council Members:

Susan Swider, PhD, APHN-BC
American Association of Colleges of Nursing

Beverly Taylor, MD
American College of Preventive Medicine

Association for Community Health Improvement

Amy Lee, MD, MPH, MBA
Association for Prevention Teaching and Research

Gary Gilmore, MPH, PhD, MCHES
Association of Accredited Public Health Programs

Philip Amuso, PhD
Association of Public Health Laboratories

Lynn Goldman, MD, MS, MPH
Association of Schools and Programs of Public Health

Wendy Braund, MD, MPH, MSEd, FACPM
Association of State and Territorial Health Officials

Association of University Programs in Health Administration

Rebecca Gold, JD
Centers for Disease Control and Prevention

Barbara Gottlieb, MD
Community-Campus Partnerships for Health

Laura Rasar King, MPH, MCHES
Council on Education for Public Health

Health Resources and Services Administration

Beth Ransopher, RS, MEP
National Association of County and City Health Officials

Christina Dokter, MA, PhD
National Association of Local Boards of Health

Carolyn Harvey, PhD
National Environmental Health Association

Lisa Lang, MPP
National Library of Medicine

Patrick Lenihan, PhD
National Network of Public Health Institutes

Louis Rowitz, PhD
National Public Health Leadership Development Network

Susan Little, DNP, RN, PHNA-BC, CPHQ
Quad Council Coalition of Public Health Nursing Organizations

Michael Fagen, PhD, MPH
Society for Public Health Education

Matthew Clark
Veterans Health Administration

3. Draft Meeting Minutes – December 12, 2017

Council on Linkages Between Academia and Public Health Practice Virtual Meeting

Date: December 12, 2017

Meeting Minutes – Draft

Members and Designees Present: Wendy Braund, Christina Dokter, Michael Fagen, Gary Gilmore, Jerry Glandon, Rita Kelliher, Laura Rasar King, Lisa Lang, Patrick Lenihan, Susan Little, Beth Ransopher, Al Richmond

Other Participants Present: Angela Aidala, Janet Aikins, Magali Angeloni, Sophia Anyatonwu, Caroline Bartha, Debra Bragdon, Vera Cardinale, LeAnna Cates, John Contreras, Yvette Daniels, Teresa Daub, Ashley Edmiston, Kaitlin Emrich, Steven Godin, Nadim Haddad, Heather-Lyn Haley, Terry Helinski, Tanya Honderick, Barbara Ann Hughes, Jonathan James, Karyn Johnstone, Lolita Kirk, Vanessa Lamers, Joan Lane, Laura Magana, Bryn Manzella, Viviana Martinez-Banchi, Phyllis Meadows, Meagan Mikkelsen, Candace Nelson, Janet Place, Hope Rollins, Russ Rubin, Lisa Sedlar, Samantha Shaver, Lenee Simon, Cyndi Stern, Bobbi Sykes, Shari Tedford, J.T. Theofilos, Hugh Tilson, Laura Valentino, Jack Wong, Laura Zeigen

Staff Present: Ron Bialek, Kathleen Amos, Janelle Nichols, Keiona Jones

Agenda Item	Discussion	Action
Welcome and Overview of Agenda	The meeting began with a welcome by Council Director Ron Bialek, MPP. Mr. Bialek shared regrets from Council Chair C. William Keck, MD, MPH, who was unable to attend. Mr. Bialek reminded participants of the Council's mission and reviewed the agenda for the meeting. Mr. Bialek introduced a new Council staff member: Keiona Jones, Project Assistant, Public Health Foundation (PHF).	
Approval of Minutes from October 2, 2017 Meeting ➢ **Action Item: Vote on Approval of Minutes**	Mr. Bialek asked for any changes to the minutes from the October 2, 2017 Council meeting. Gary Gilmore, MPH, PhD, MCHES, moved to approve the minutes as written. Lisa Lang, MPP, seconded the motion. No additions or corrections.	Minutes of the October 2, 2017 Council meeting were approved as written.
Request for Council Membership Vote – Veterans Health Administration ➢ **Action Item: Vote on Membership Request**	Mr. Bialek informed the Council that the Veterans Health Administration (VHA) has requested to join the Council. Mr. Bialek welcomed Karyn Johnstone, MPH, National Coordinator of Interagency Shared Training, VHA Employee Education System, to speak on behalf of VHA. Mr. Bialek asked for discussion on granting preliminary membership to VHA. Dr. Gilmore moved to grant preliminary membership. Susan Little, DNP, RN, PHNA-BC, CPHQ, seconded the motion.	VHA was granted preliminary Council membership.

DRAFT

CDC: Public Health Associate Program	J.T. Theofilos, MBA, Team Lead, Partnerships and Stakeholder Engagement, Public Health Associate Program (PHAP), Centers for Disease Control and Prevention (CDC), shared information about CDC's PHAP program and opportunities to participate in the program as a host site or associate. PHAP is a two-year training program with the CDC that places associates in public health agencies and nongovernmental organizations across the US. For the next PHAP class, which starts in October 2018, the application period for associates will be open from January 2-8, 2018, and for prospective host sites from January 2-18, 2018.	
The Kresge Foundation: Emerging Leaders in Public Health Initiative	Guest speaker Phyllis Meadows, PhD, Senior Fellow – Health, The Kresge Foundation, discussed Kresge's Emerging Leaders in Public Health (ELPH) Initiative. ELPH is a program to develop public health leaders in which a public health officer and emerging leader work together as a team. The application period for the third ELPH cohort is expected to open in mid-2018 Mr. Bialek invited questions for Dr. Meadows.	Council staff will share information about the ELPH application period with the Council when it is available. Questions about Kresge's ELPH Initiative can be sent to Kathleen Amos at kamos@phf.org.
Advocating for the Public Health Workforce: The Role of the Council	Guest speaker and former Council member, Hugh Tilson, MD, DrPH, MPH, spoke to the Council about the role of the Council in advocating for the public health workforce, the Council's long history of doing so, and opportunities for the Council moving forward.	Council staff will invite Dr. Tilson to continue this discussion at a future Council meeting.
Demonstrating Council Impact	Mr. Bialek asked Council members to share examples of ways the Council's work has impacted Council member organizations' members and constituents. This will assist in documenting the collective impact of the Council.	Examples of ways the Council's work has impacted Council member organizations' members and constituents can be shared with Kathleen Amos at kamos@phf.org.
Council Member Request: New Approaches to Practice-based Research	The Council offers a venue for individual member organizations to raise topics for discussion that could benefit from input of other Council member organizations. Council member organizations are welcome to take advantage of this as needs and opportunities arise. The National Network of Public Health Institutes' Council representative, Patrick Lenihan, PhD, led a discussion on the need for new approaches to practice-based research and for leadership and advocacy to promote this.	Topics Council member organization would like to propose for discussion at Council meetings can be shared with Kathleen Amos at kamos@phf.org. Council staff will discuss with the Council Chair bringing this topic to the Academic Health Department (AHD) Learning Community for

	Mr. Bialek invited discussion or questions for Dr. Lenihan.	further discussion.
Performance Improvement and Population Health Competencies	Council Assistant Director Kathleen Amos, MLIS, provided an update on the efforts to develop performance improvement (PI) and population health competencies. Two draft sets of discipline-specific competencies based on the Core Competencies for Public Health Professionals (Core Competencies) will soon be open for feedback to help with refining and finalizing each set. The draft PI Competencies define and describe skills and competencies desirable for PI professionals working in public health, and expand upon PI concepts present in the Core Competencies. These draft competencies have been refined based on feedback from the public health community and an environmental scan, and the current draft contains 19 competencies. A PI Competencies Subgroup was created under the Core Competencies Workgroup and provides guidance for this effort. The draft Priority Competencies for Population Health Professionals began as a collaboration between PHF and the Association for Community Health Improvement to describe desired skills for population health professionals and are primarily designed for non-clinical hospital, health system, public health, and healthcare professionals engaged in assessment of population health needs and development, delivery, and improvement of population health programs, services, and practices. Feedback has been collected and used to refine these competencies over the past year. The current draft of these competencies contains 31 competencies organized into 5 categories.	
	As the feedback process begins for both of these draft competency sets, additional information will be shared in a variety of ways, including through the Council on Linkages Update, PHF E-News, Core Competencies Workgroup, and PI Competencies Subgroup. Feedback on these draft competency sets is welcome and encouraged. Help in sharing the feedback opportunity will also be appreciated. Feedback is expected to be accepted through February or March 2018 and will be used to refine the competency sets, with the goal of releasing both sets by mid-2018.	Feedback on the draft PI Competencies or Priority Competencies for Population Health Professionals may be shared with Kathleen Amos at kamos@phf.org. Council staff will contact Council member organizations, as appropriate, for assistance in disseminating requests for feedback on these

	Mr. Bialek invited questions for Ms. Amos.	draft competency sets.
Core Competencies for Public Health Professionals	Core Competencies Workgroup Co-Chair Janet Place, MPH, provided an update on work related to the Core Competencies and progress made during 2017. To date in 2017, the Core Competencies have been accessed nearly 37,000 times, and resources and tools that support use of the Core Competencies have been accessed close to 70,000 times. The most popular resources and tools include competency assessments and collections of job descriptions, examples of how organizations use the Core Competencies, and workforce development plans. Both the Association of State and Territorial Health Officials (ASTHO) and National Association of County and City Health Officials (NACCHO) released updated data about use of the Core Competencies by health departments through their Profile studies this year. The ASTHO Profile study, based on research conducted in 2016, indicates that approximately 80% of state health departments use the Core Competencies. The 2016 National Profile of Local Health Departments study conducted by NACCHO shows a 73% increase in use of the Core Competencies among local health departments since the study was last completed in 2013 – with usage growing from 26% to 45%. To support organizations in using the Core Competencies, a modified version of the Core Competencies was developed and is available through the Council website. This version is based on Tier 2 of the Core Competencies and groups competencies that share a common theme together to reduce the number of individual items to focus on in workforce development efforts. A new Core Competencies tool, *Determining Essential Core Competencies for Public Health Jobs: A Prioritization Process*, was released in June 2017 and featured in a webinar and sessions at the 2017 Public Health Improvement Training and American Public Health Association Annual Meeting. Twelve new job descriptions and a new workforce development plan that incorporate the Core Competencies were added to the existing online collections of these resources, and additional examples for these collections are welcome. Competency sets that draw on the Core Competencies also continued to be developed, including the Population Health Competencies and PI Competencies. Earlier in 2017, after considering requests from	Additional examples that can be included in the collections of job descriptions and workforce development plans that incorporate the Core Competencies, as well as other examples of how the Core Competencies are being

	the public health community and usage of the Core Competencies, the Council determined that the Core Competencies would not be opened for review this year, allowing work to be done to develop these tools and resources to continue to support use of the Core Competencies. Additionally in 2017, Council staff participated in a Public Health Workforce Interest and Needs Survey (PH WINS) workgroup to support the incorporation of concepts from the Core Competencies into their assessment tool; the Core Competencies Workgroup grew to nearly 100 members and began a discussion of Council involvement in recognition of discipline-specific competency sets based on the Core Competencies; and the PI Competencies Subgroup was formed with nearly 90 members to support refinement of the PI Competencies. Three blog posts and one news article highlighting work related to the Core Competencies were published on the PHF website and viewed more than 500 times, and Council staff responded to more than 40 distance technical assistance (TA) requests, serving nearly 40 organizations in 19 states, Guam, and Uganda. Mr. Bialek invited questions about activities related to the Core Competencies.	used, are welcome by email to Janelle Nichols at jnichols@phf.org.
Academic Health Department Learning Community	Ms. Amos provided an update on activities of the AHD Learning Community in 2017. The AHD Learning Community was involved in a variety of activities in 2017, including development and enhancement of tools and resources, hosting of virtual meetings, and development and dissemination of related communications. The Learning Community grew to approximately 750 members, representing organizations in all 50 states, DC, and four US territories. To date in 2017, the Learning Community and its resources and tools have been accessed more than 6,000 times, and Council staff responded to more than 25 requests for distance TA, serving more than 20 organizations in 13 states. Four AHD Learning Community meetings were held in March, May, July, and September to highlight progress being made on AHD partnerships. All of these meetings were recorded and are available through the Council website, TRAIN Learning Network, and YouTube. A new quarterly Ask the AHD Expert series was launched on the PHF Pulse blog, with columns published in March, June, and	

	September, and a fourth planned for December. A staged model of AHD development was drafted, with the aim of better articulating how AHD partnerships might develop. This model illustrates the potential development of such partnerships on a continuum and is currently open for feedback. An article describing the development of the AHD Research Agenda was published in the September 2017 issue of the *American Journal of Public Health*. Seven AHD partnerships were added to the list of AHD partnerships on the Council website, and three partnership agreements were added to the collection of AHD partnership agreements. The AHD Mentorship Program created seven additional mentor-mentee matches, bringing the current total to 15 pairs working together to move AHD efforts forward. Mr. Bialek invited questions about the AHD Learning Community.	Feedback related to the draft staged model of AHD development may be shared with Kathleen Amos at kamos@phf.org. Additional AHD partnerships or AHD partnership agreements that can be added to the Council website can be sent to Janelle Nichols at jnichols@phf.org. Expressions of interest in participating in the AHD Mentorship Program as a mentor or mentee can be sent to Janelle Nichols at jnichols@phf.org.
Other Business and Next Steps	Mr. Bialek reiterated the request for input from Council members about the impact of the Council and its resources and tools. Mr. Bialek asked if there was any other business to address. Future Council meetings have not been scheduled, but will likely be held virtually. Council staff will be in contact with Council members to schedule meetings for 2018.	Input on the impact of the Council and its resources and tools may be shared with Kathleen Amos at kamos@phf.org. Council staff will schedule meetings for 2018.

4. State of the Council: Where We've Been, Where We Are, Where We're Headed

State of the Council Report

July 16, 2018

Overview

For more than 25 years, the Council on Linkages Between Academia and Public Health Practice (Council) has been providing support for the US public health workforce and advancing workforce development efforts nationwide. This has included early work to lay the groundwork for The Community Guide (The Guide to Community Preventive Services) and the field of public health services and systems research (PHSSR), contributions to Council on Education for Public Health accreditation for schools and programs of public health and Public Health Accreditation Board accreditation for health departments, development of foundational competencies for the practice and teaching of public health, and strengthening partnerships and collaboration between public health practice and academia. Over this history, the Council has grown from nine member organizations to 23, expanding its breadth and bringing in a range of stakeholders whose efforts align in the goal of improving the public's health.

Discussion during this Council meeting will focus on: 1) the impact of the Council; 2) current Council initiatives; and 3) future opportunities for the Council. Council members will have an opportunity to share ways the Council's work has impacted their organizations and constituents as part of this discussion.

5. **Core Competencies for Public Health Professionals**:
    - **Core Competencies for Public Health Professionals Report**
    - **Competencies for Performance Improvement Professionals in Public Health**
    - **Quad Council Coalition's 2018 Community/Public Health Nursing Competencies**

Core Competencies for Public Health Professionals Report

July 16, 2018

Overview
The Core Competencies for Public Health Professionals (Core Competencies) reflect foundational skills desirable for professionals engaged in the practice, education, and research of public health and are used in education, training, and other workforce development activities across the country. The current version of the Core Competencies was released by the Council on Linkages Between Academia and Public Health Practice (Council) in June 2014. Council efforts related to the Core Competencies are guided by the Core Competencies Workgroup, which has more than 90 members representing a variety of practice and academic organizations and interests within the public health field.

Core Competencies Use
The Core Competencies continue to be widely used within public health workforce development. Since release of the current version of the Core Competencies in 2014, the Core Competencies have been accessed online more than 180,000 times, and resources and tools designed to support implementation of the Core Competencies have been accessed online more than 510,000 times. Recent data from the Association of State and Territorial Health Officials and National Association of County and City Health Officials show that approximately 80% of state health departments and 45% of local health departments are using the Core Competencies. Tools to support this use continue to be a focus, with a competency assessment based on the modified version of the Core Competencies released last year currently under development. Work also continues to better highlight how organizations are using the Core Competencies. A redesign of a section of the Council website to highlight these stories and examples is underway, and additional stories and examples to feature on the Council website are welcome and may be sent to Kathleen Amos at kamos@phf.org.

Healthy People 2030
The Core Competencies are integrated into three objectives within the Public Health Infrastructure (PHI) topic area of Healthy People 2020. These objectives focus on the use of the Core Competencies in public health agency job descriptions and performance evaluations, continuing education, and academic curricula. Planning is currently underway for Healthy People 2030, and earlier this year, Council staff met with the team working on the PHI topic area to offer input into PHI objectives. Work toward determining objectives is still in process, but it is anticipated that Healthy People 2030 will include many fewer objectives than Healthy People 2020. As work to develop Healthy People 2030 continues, a public comment period will offer an opportunity to provide addition input into the objectives. The Council will be informed when that public comment period opens, which is likely to be toward the end of this year.

New Competencies Released
In addition to supporting development of foundational, or cross-cutting, skills for professionals working in public health, the Core Competencies support the development of discipline-specific competency sets. A variety of competency sets have drawn on the Core Competencies and the expertise of Council staff and Core Competencies Workgroup members in their development and implementation. For example, within the past two years, Council staff and Core Competencies Workgroup members have engaged in efforts related to the Competencies for Performance Improvement Professionals in Public Health, Competencies for Population Health Professionals, Competencies Guidelines for Public Health Laboratory Professionals, Including

People with Disabilities: Public Health Workforce Competencies, and Legal Epidemiology Competency Model. Additional competency sets that draw on the Core Competencies include the Community/Public Health Nursing Competencies, Competencies for Applied Epidemiologists in Governmental Public Health Agencies, Competencies for Health Education Specialists, and Competencies for Public Health Informaticians.

Competencies for Performance Improvement Professionals in Public Health
The Competencies for Performance Improvement Professionals in Public Health (PI Competencies), a set of skills desirable for performance improvement (PI) professionals working in public health, were developed to offer additional guidance in PI for public health professionals with responsibilities related to developing or implementing plans and activities in the areas of quality improvement, performance management, workforce development, accreditation readiness, or community health assessment and improvement planning. Released in June 2018 by the Public Health Foundation, these competencies are based on and align with the Core Competencies, and can be used along with the Core Competencies to help guide workforce development for PI professionals. To support public health professionals and organizations in using the PI Competencies, a supplemental resource that presents the PI Competencies along with a list of competencies from the Core Competencies that may be especially relevant for PI professionals was also developed. Work on this competency set and related resource was guided by the Performance Improvement Competencies Subgroup of the Core Competencies Workgroup, which includes more than 80 members.

Community/Public Health Nursing Competencies
The Quad Council Coalition of Public Health Nursing Organizations recently released the 2018 Community/Public Health Nursing (C/PHN) Competencies, which were updated to align with the current version of the Core Competencies, as well as a variety of other related nursing competencies. The C/PHN Competencies use the same eight domains and three-tier structure as the Core Competencies. The C/PHN Competencies reflect the unique competencies required for the practice of public health nursing and can be used by public health nurses from entry-level to senior management/leadership in a variety of practice settings.

More information about the Core Competencies and Core Competencies activities is available through the Core Competencies section of the Council website or by contacting Kathleen Amos at kamos@phf.org.

Core Competencies Workgroup Members

Co-Chairs:

- Amy Lee, Northeast Ohio Medical University
- Janet Place, Arnold School of Public Health, University of South Carolina

Members:

- Nor Hashidah Abd Hamid
- Angela Aidala, Region 2 Public Health Training Center, Columbia University
- Liz Amos, National Library of Medicine
- Sandra Anyanwu-nzeribe
- Sophia Anyatonwu, Texas Department of State Health Services, Region 7
- Sonja Armbruster, College of Health Professions, Wichita State University
- Bobbie Bagley, Nashua Division of Public Health & Community Services (NH)
- Cynthia Baker, Prince George's County Health Department (MD)
- Noel Bazini-Barakat, Los Angeles County Department of Public Health (CA)
- Dawn Beck, Olmsted County Public Health Services (MN)
- Roxanne Beharie, Ashford University
- Alan Bergen, Pima County Health Department (AZ)
- Linda Beuter, Livingston County Department of Health (NY)
- Michael S. Bisesi, College of Public Health, The Ohio State University
- Jeanne Bowman, Champaign Health District (OH)
- Keree Brannen, Austin Public Health (TX)
- Tom Burke, Bloomberg School of Public Health, Johns Hopkins University
- Belinda Caballero, David Jurkovich MD PLLC; BC Billing LLC (FL)
- Candy Cates, Oregon Health Authority
- Marita Chilton, Public Health Accreditation Board
- Michelle Chino, School of Community Health Sciences, University of Nevada, Las Vegas
- Samantha Cinnick, Region 2 Public Health Training Center, Columbia University
- Michelle Cravetz, School of Public Health, University at Albany
- Oriyomi Dawodu, School of Medicine, University of Maryland
- Marilyn Deling, Olmsted County Public Health Services (MN)
- Anjali Deshpande, College of Public Health, University of Iowa
- Diane Downing
- Mark Edgar, School of Medicine and Public Health, University of Wisconsin
- Dena Fife
- Colleen Fitzgibbons, The Ohio State University
- Linda Rose Frank, Graduate School of Public Health, University of Pittsburgh
- Jen Freiheit, Bay View Advanced Management, LLC
- Kristine Gebbie
- Brandon Grimm, College of Public Health, University of Nebraska Medical Center
- John Gwinn, University of Akron
- Viviana Horigian, University of Miami
- Emmanuel Jadhav, Ferris State University
- Larry Jones
- Vinitsa Karatsu, County of Los Angeles Department of Public Health (CA)
- Bryant T. Karras, Washington State Department of Health
- Laura Rasar King, Council on Education for Public Health
- David Knapp, Kentucky Department for Public Health
- Kathy Koblick, Marin County Department of Health and Human Services (CA)
- Kirk Koyama, Health Resources and Services Administration
- Rajesh Krishnan, The Preventiv

- Cynthia Lamberth
- Angela Landeen, University of South Dakota
- Lisa Lang, National Library of Medicine
- Caitlin Langhorne, Association of State and Territorial Health Officials
- Jessie Legros, Centers for Disease Control and Prevention
- Jami Lewis, Clay County Public Health Center (MO)
- Jen Lewis, Sonoma County Department of Health Services (CA)
- Linda Lewis, Butte County Public Health Department (CA)
- Karina Lifschitz, Centers for Disease Control and Prevention
- John Lisco, Council of State and Territorial Epidemiologists
- Ruth Little, Brody School of Medicine, East Carolina University
- Susan Little, North Carolina Division of Public Health
- Kathleen MacVarish, School of Public Health, Boston University, New England Public Health Training Center
- Lynn Maitlen, Dubois County Health Department (IN)
- Bryn Manzella, Jefferson County Department of Health (AL)
- Jeanne Matthews, Malek School of Health Professions, Marymount University
- Eyob Mazengia, Public Health – Seattle & King County (WA)
- Mia McCray, East Orange Fire Prevention (NJ)
- Tracy Swift Merrick, Agora Cyber Charter School
- Nadine Mescia, University of Tampa
- Kathy Miner, Rollins School of Public Health, Emory University
- Casey Monroe, Allegheny County Health Department (PA)
- Sophie Naji, University of Illinois at Chicago, Great Lakes Public Health Training Collaborative
- Ifeoma Ozodiegwu
- Scott Pegues, Denver Public Health; Denver Prevention Training Center
- Christina Ramsey, Health Resources and Services Administration
- Penney Reese, Centers for Disease Control and Prevention
- Beth Resnick, Bloomberg School of Public Health, Johns Hopkins University
- Victoria Rivkina, DePaul University
- Mitchel Rosen, Rutgers School of Public Health
- Elizabeth Rumbel, Denver Public Health (CO)
- Y. Silvia Shin, County of Los Angeles Department of Health (CA)
- Mark Siemon, Idaho Public Health
- Lillian Upton Smith, Boise State University
- Rochelle Spielman, Minnesota Department of Health
- Chris Stan, Connecticut Department of Public Health
- Ran Tao, Jefferson County Public Health (CO)
- Douglas Taren, The University of Arizona
- Shari Tedford, Johnson County Department of Health and Environment (KS)
- Graciela Tena de Lara, Wyoming Department of Health
- Valencia Terrell, Centers for Disease Control and Prevention
- Allison Thrash
- Michelle Tissue, Health Resources and Services Administration
- Karen A. Tombs, The Dartmouth Institute for Health Policy and Clinical Practice
- Griselle Torres, University of Illinois at Chicago
- Kathi Traugh, Yale School of Public Health, Yale University
- Andrew Wapner, College of Public Health, Ohio State University
- Sharonda Willis, California Department of Health
- Laura Zeigen, Oregon Health & Science University

Competencies for Performance Improvement Professionals in Public Health

June 1, 2018

The Competencies for Performance Improvement Professionals in Public Health (PI Competencies) are a set of skills desirable for performance improvement (PI) professionals working in public health. Based on the Core Competencies for Public Health Professionals (Core Competencies) and the Core Competencies for Performance Improvement Managers, these competencies were developed to offer additional guidance in PI for public health professionals with responsibilities related to developing or implementing plans and activities in the areas of quality improvement, performance management, workforce development, accreditation readiness, or community health assessment and improvement planning.

The PI Competencies describe areas of skills and knowledge beneficial to PI professionals. These competencies do not describe specific tasks or activities performed by PI professionals, as those are determined by places of employment. As the field of PI encompasses a number of distinct jobs or positions within public health organizations, individual competencies within the PI Competencies may be more or less relevant for individual PI professionals based on their specific job responsibilities. Individual PI professionals are encouraged to focus on developing competencies in the areas most relevant to their jobs.

Connection with the Core Competencies for Public Health Professionals

The PI Competencies align with the Core Competencies, a set of foundational skills for all professionals working in public health. The PI Competencies expand upon PI concepts present in the Core Competencies and describe additional skills focused more specifically on the work of PI professionals in public health settings, such as state, Tribal, local, and territorial health departments. PI-related skills addressed in the Core Competencies are not repeated in the PI Competencies. The PI Competencies are designed to be used along with the Core Competencies to help guide development of job descriptions, performance objectives, training, workforce development plans, academic curricula, tools, and other resources to support the activities and growth of PI professionals.

Development of the PI Competencies

Development of the PI Competencies was supported by the Performance Improvement Competencies Subgroup of the Council on Linkages Between Academia and Public Health Practice's Core Competencies Workgroup and shaped by input from numerous PI professionals working in public health. Development was informed by a comprehensive environmental scan that included a review of literature and resources related to competency development and opportunities for PI professionals to provide feedback about the key knowledge, skills, and abilities needed for working in this area. In addition, the PI Competencies reflect input from national organizations and technical assistance providers and trainers who have worked with over 500 health departments on PI activities.

Organization of the PI Competencies

To facilitate use with the Core Competencies, the PI Competencies are organized using the same domain structure and names used in the Core Competencies. The PI Competencies expand on competencies addressed in the Core Competencies within five of the Core Competencies domains:

- Analytical/Assessment Skills
- Policy Development/Program Planning Skills
- Community Dimensions of Practice Skills
- Financial Planning and Management Skills
- Leadership and Systems Thinking Skills

It is important to note that competencies within the Core Competencies are also beneficial for PI professionals. A list of competencies within all eight domains of the Core Competencies that may be especially relevant for PI professionals can be found in the supplemental resource, *Competencies for Performance Improvement Professionals in Public Health: Alignment with the Core Competencies for Public Health Professionals*.

Feedback on the Core Competencies

The Public Health Foundation thanks the public health community for its contributions to the PI Competencies and welcomes feedback about the PI Competencies. Examples illustrating how public health professionals and organizations are using the PI Competencies and tools that facilitate PI Competencies use are also appreciated. Feedback, suggestions, examples of use, and resources can be shared by emailing competencies@phf.org.

For More Information

Additional information about the PI Competencies can be found at phf.org/PICompetencies. Questions or requests for information may be sent to competencies@phf.org.

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Competencies for Performance Improvement Professionals in Public Health

Analytical/Assessment Skills

1. Demonstrates how data and information are used to improve individual, program, and organizational performance (e.g., selection and use of valid and reliable quantitative and qualitative data, data-driven decision making, data management, performance measurement)
2. Uses evidence (e.g., literature, best practices, model/promising/emerging practices) in determining how to evaluate and improve performance

Policy Development/Program Planning Skills

3. Describes how quality improvement, performance management, and workforce development are used to improve individual, program, and organizational performance
4. Coordinates development and implementation of an organization-wide quality improvement plan
5. Coordinates development and implementation of an organization-wide workforce development plan
6. Applies quality improvement, performance management, and workforce development frameworks, methods, tools, and models to improve individual, program, and organizational performance
7. Evaluates the effectiveness and quality of the organization's quality improvement, performance management, and workforce development plans and practices
8. Integrates quality improvement methods into organizational policies, plans, programs, and services
9. Aligns quality improvement plan and performance management system with other organization and community plans (e.g., strategic plan, community health improvement plan, workforce development plan, communication plan, all hazards emergency operations plan)

Community Dimensions of Practice Skills

10. Describes how quality improvement, performance management, and workforce development can be used to achieve equity within the organization and health equity within the community
11. Uses input of and feedback from internal and external customers in developing, implementing, and evaluating quality improvement, performance management, and workforce development activities
12. Collaborates with others internal and external to the organization (e.g., relationships with HR office, partnerships with health systems) in developing, implementing, and evaluating activities to improve individual, program, and organizational performance

Financial Planning and Management Skills

13. Demonstrates interpersonal skills that support activities to improve individual, program, and organizational performance (e.g., encouragement, optimism, compassion, empathy, resilience, recognition of the value of performance improvement)
14. Builds teams from all levels of the organization to improve program and organizational performance
15. Coordinates development and implementation of an organization-wide performance management system
16. Uses evaluation results and the performance management system to improve individual, program, and organizational performance

Leadership and Systems Thinking Skills

17. Develops skills of others within the organization in quality improvement and performance management
18. Ensures continuous improvement of quality improvement policies and programs, the performance management system, and workforce development policies and programs
19. Advocates for the use of quality improvement, performance management, and workforce development methods, tools, and practices throughout the organization (e.g., creates organization buy-in, overcomes resistance, communicates value, develops a culture of quality, supports a culture of learning, encourages innovation)

Community/Public Health Nursing [C/PHN] Competencies (Quad Council Coalition, 2018)

The Quad Council Coalition (QCC) of Public Health Nursing Organizations is comprised of:

- Alliance of Nurses for Healthy Environments (AHNE)
- Association of Community Health Nursing Educators (ACHNE)
- Association of Public Health Nurses (APHN)
- The American Public Health Association – Public Health Nursing Section (APHA-PHN)

The QCC was founded in 1988 to address priorities for public health nursing education, practice, leadership, and research, and as the voice of public health nursing.

QCC Competency Review Task Force, 2017-2018
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Introduction

The Quad Council Coalition (QCC) of Public Health Nursing Organizations is comprised of the Alliance of Nurses for Healthy Environments (AHNE), Association of Community Health Nursing Educators (ACHNE), Association of Public Health Nurses (APHN), and the American Public Health Association Public Health Nursing Section (APHA PHN). The Quad Council Coalition (QCC) of Public Health Nursing Organizations was founded in 1988 and represents nursing professional groups active in public health teaching and practice; its vision and mission are to provide the "voice and visibility for public health nurses." The QCC "sets a national policy agenda on issues related to public health nursing and advocates for excellence in public health nursing education, practice, leadership, and research" (Quad Council Coalition [QCC], 2017, p. para.1). In 2011, the QC revised the *Quad Council Competencies for Public Health Nurses* (QCC-PHN) to guide three levels of practice: *Tier one* generalist, *Tier two* management or supervisory, and *Tier three* senior management or leadership (Swider, Krothe, Reyes, & Cravetz, 2013). The QCC-PHN were designed to inform and improve the public health workforce (Quad Council Coalition [QCC], 2017). Practice and education based on *competency* is an important goal (Joyce et al., 2017). Six years after the approval of the 2011 *Core Competencies for Public Health Nursing*, the QCC appointed a Competency Review Task Force charged with review and revision of the *Core Competencies for Public Health Nursing* (Quad Council, 2011, Summer). The Task Force was comprised of members representing QCC member organizations and all levels of practice, education, and research. The Community/Public Health Nursing (C/PHN) competencies grew out of the effort to rebrand the competencies to be more inclusive, more fully reflect the definition of *Public Health Nursing* (American Public Health Association Public Health Nursing Section [APHA PHN, 2013), and create conditions for community and public health nurses to be active participants in Public Health 3.0 (DeSalvo, Wang, Harris, Auerbach, Koo, & O'Carroll, 2017). In addition to the revised *competencies,* an evaluation tool was developed as a template for practice, education, and in research activities (See Appendix 1).

Methods

The Task Force members included representatives from education and practice for each Tier (generalist, supervisory management, senior leadership/management). Work on the revisions took place in March through October 2017. An attempt was made to use the revised Bloom's Taxonomy Action Verbs (Anderson et al., 2001) for each *competency* statement. A cross-walk matrix was developed to strengthen the C/PHN and align them with the Core Competencies for Public Health Professionals (Council on Linkages Between Academia and Public Health Practice [CoL], 2014, June). Finally, other sets of competencies were used in the matrix to support additions or changes in the revised draft. Reviewed competencies included: AONE Nurse Executive and Nurse Manager Competencies (American Organization of Nurse Executives [AONE], 2015), World Health Organization (2016) Nurse Educator Core Competencies, Competencies in Occupational & Environmental Health Nursing (American Association of Occupational Health Nurses [AAOHN], 2015), Global Health Competencies (Wilson et al., 2012) and Interprofessional Global Health Competencies (Jogerst et al.,

2015). Also, a critical review of the literature provided manuscripts and documents to guide revision (Joyce et al., 2017; Robert Wood Johnson Foundation Public Health Nurse Leaders [RWJPHNL], 2017, August).

Each QCC member organization was asked to participate in two rounds of a Delphi process as a crucial strategy to capture insights and feedback from subject matter experts (Hsu & Sandford, 2007). The initial Delphi process began November 15, 2017 and ended February 1, 2018. Member organizations were provided recommended procedures for the review and supporting documents. It was recommended that each organization mirror the Task Force's process. The Task Force suggested each organization appoint a committee that includes representatives from each of the three Tiers, which are to be divided into Tiers 1-3 (Table 1) and Domains (1-8). The appointed leader served as the point of contact to the QCC Competency Review Task Force. As a suggested example, a group of 3-4 members can be assigned to Tier 1, and each can review two *competency* Domains. Once the within-Tier review is completed, the committee will want to look horizontally across the Tiers to pick up redundancy and ensure a natural progression of competencies across the three Tiers. Criteria for *competency* review included: competencies can stand alone, competencies between Tiers demonstrate a natural progression of knowledge, skills, and attitudes, and competencies are forward thinking.

An Excel spreadsheet with the draft C/PHN competencies revisions was crafted to outline the Delphi *competency* review process. The Delphi *competency* review form included three columns with the following headings: Tier/Domain, organizational comment(s), QCC Review Team comment(s), and all supporting documents. Supporting documents included: Bloom's Taxonomy (Anderson et.al., 2001), the Core Competencies for Public Health Professionals (Council on Linkages Between Academia and Public Health Practice [CoL], 2014, June), AONE Nurse Executive and Nurse Manager Competencies (American Organization of Nurse Executives [AONE], 2015), World Health Organization (2016) Nurse Educator Core Competencies, Competencies in Occupational & Environmental Health Nursing (American Association of Occupational Health Nurses [AAOHN], 2015), Global Health Competencies (Wilson et al., 2012) and Interprofessional Global Health Competencies(Jogerst et al., 2015).

Feedback from QCC member organizations was incorporated by the Task Force. The revised draft was sent back to member organizations for the second Delphi round on March 7, 2018, with feedback due March 23, 2018. Final feedback was integrated and sent to the QCC for review and approval March 26, 2018.

Summary

The C/PHN competencies were approved by the QCC April 13, 2018. The C/PHN competencies are consistent with the definition of *Public Health Nursing* (American Public Health Association Public Health Nursing Section [APHA PHN], 2013) and the Scope and Standards of Public Health Nursing (American Nurses Association [ANA], 2013). Therefore, the competencies may be used at all

levels and in a variety of practice settings. The competencies are useful to guide and revolutionize practice, education, research, and policy at all levels.

Levels of Practice

PHNs practice in diverse settings and environments. Thus these competencies represent the continuum of evolving PHN practice roles, responsibilities, and functions for which PHNs may have to account (Quad Council, 2011).

The **baccalaureate degree in nursing (BSN)** is the established educational preparation for entry level C/PHN practice (ANA, 2013; ACHNE, 2009, p. 12; Quad Council, 2011). The BSN provides an essential framework of liberal arts and sciences education that serves as a foundation for PHN practice. From this framework, C/PHNs understand how personal, social, policy, economic, work, and environmental determinants affect health status of individuals, communities, and populations. BSN education prepares PHNs both didactically and clinically.

As in the previous iteration of these competencies, the Quad Council Coalition reaffirmed that a C/PHN generalist has entry-level preparation at the baccalaureate level, reflected by Tier 1 competencies. **True, in many areas of the US, nurses work in public health without the BSN.** However, the Quad Council Coalition believes that those nurses may require a job description that reflects a differentiated level of practice and/or may require extensive orientation and education to successfully achieve generalist competencies in Tier 1.

Table 1: C/PHN Competencies Tiers 1-3.

Tier 1 C/PHN Competencies	Tier 2 C/PHN Competencies	Tier 3 C/PHN Competencies
Tier 1 Core Competencies apply to generalist community/public health nurses (C/PHN) who carry out day-to-day functions in community organizations or state and local public health organizations, including clinical, home visiting and population-based services, and who are not in management positions. Responsibilities of the C/PHN may include working directly with at-risk-populations, carrying out health promotion programs at all levels of prevention, basic data collection and analysis, field work, program planning, outreach activities, programmatic support, and other organizational tasks. Although the CoL competencies and the C/PHN competencies are primarily focused at the population level, C/PHNs must often apply these skills and competencies in the provision of services to individuals, families, or groups. Therefore, Tier 1 competencies reflect this practice.	**Tier 2 Core Competencies** apply to C/PHNs with an array of program implementation, management, and supervisory responsibilities, including responsibility for clinical services, home visiting, community-based and population-focused programs. For example, responsibilities may include: implementation and oversight of personal, clinical, family focused, and population-based health services; program and budget development; establishing and managing community relations; establishing timelines and work plans, and presenting recommendations on policy issues.	**Tier 3 Core Competencies** apply to C/PHNs at an executive or senior management level and leadership levels in public health or community organizations. In general, these competencies apply to C/PHNs who are responsible for oversight and administration of programs or operation of an organization, including setting the vision and strategy for an organization (i.e., a public health department, public health nursing division, or executive director of a non-profit community organization). Tier 3 professionals generally are placed at a higher level of positional authority within the agency/organization, and they bring similar or higher-level knowledge, advanced education, and experience than their Tier 2 counterparts.

Note: Levels of mastery (Tiers 1-3) within each competency will differ depending upon the professional's backgrounds, job duties, and ears of experience.

Assumptions

1. Use of the steps of the nursing process innervates public health nursing practice. Assessment, diagnosis, planning, intervention, and evaluation are foundational to all essential services.
2. The C/PHN competencies were developed to build behaviors across the three tiers. An individual in an administrative Tier 3 position, whose job description does not include Tier 1 behaviors, must understand and have mastered the proceeding competencies.
3. The competencies reflect behaviors required and relevant to the Public Health Core Functions (assessment, policy development, assurance) and the 10 Essential Services.
4. Ethics is mentioned specifically in Domains 1 & 8 and cuts across all Domains of C/PHN to decrease redundancy.
5. A recommendation from a member organization suggested that the Bloom's Taxonomy (Anderson et al., 2001) should only be used as a guide and not definitive. Verbs were used "outside of the delineated boxes" that were recommended and seemed most appropriate for the tier level.
6. When referring to the behavior of "cultural responsiveness," the term includes consideration of diversity, inclusiveness, and cultural humility.
7. The word "justice" is used broadly and refers to multiple forms of justice include but are not limited to: social, environmental, economic, occupational, and distributive.
8. The term "health care team" includes the client, caregivers, and members of the community.
9. The use of the term "evidence-based" considers knowledge from public health, public health nursing, and all disciplines. Therefore, public health nurses should consider evidence and promising practices from other disciplines.
10. The term "determinants of health" has been used and assumed to encompass; personal, social, policy, economic, work, and environmental factors that influence health status (USDHHS, 2018).

Application to Education

Nurse educators in community/public health nursing (C/PHN) must use the competencies in the planning of course descriptions and objectives for C/PHN activities. Use of the competencies guide selection of clinical sites and multi-sector collaboration that provides collaborative clinical activities for baccalaureate and graduate nursing students and practicing C/PHNs. *Critical behaviors* from each Domain are a tool for formative and summative evaluation, which provides structure and rigor to C/PHN education.

Application to Practice

The C/PHN competencies provide the knowledge, skills, and behaviors necessary to mastery of competent practice. The C/PHN competencies have relevance to all C/PHNs and the agencies that employ them. Most importantly, the C/PHN competencies provide the basis for C/PHN's efforts to meet the needs of the populations C/PHNs serve and to protect and promote the health of communities locally and globally.

The three core functions of public health (assessment, policy development, and assurance) are carried out by C/PHNs as integral members of the interprofessional teams providing the CDC's (2017) 10 essential services (Table 2) in communities and for populations. In practice, C/PHNs may not use all the competencies when carrying out the ten essential services (Table 2). However, C/PHNs will be able to identify *critical behaviors* in the C/PHN competencies that are essential to their role, regardless of practice setting.

Using self-assessment, C/PHNs need to identify *competency* gaps that reflect *critical behaviors* that they desire to master and integrate into their professional development plan. C/PHNs and agencies will also benefit from the use of these competencies when designing job descriptions, orientation plans, and performance evaluation. The C/PHN competencies are foundational to practice and complementary to the specific roles of C/PHNs across various practice settings.

Table 2: Core Functions of Public Health and 10 Essential Services.

Core Functions of Public Health	10 Essential Services
Assessment - Health needs, investigate health problems, & analyze the determinates of health (medical and non-medical)	1. Monitor health status to identify and solve community health problems. 2. Diagnose and investigate health problems and health hazards in the community.
Policy Development - Advocate for resources to address needs, prioritize and address health needs, & plan & develop policies to address the priority health needs	3. Inform, educate, and empower people about health issues. 4. Mobilize community partnerships and action to identify and solve health problems. 5. Develop policies and plans that support individual and community health efforts.
Assurance - Manage resources, implement programs to address priority health needs, evaluate how those interventions are affecting populations, & informing the community about health issues that are or could impact them and the resources available to them	6. Enforce laws and regulations that protect the health and ensure safety. 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable. 8. Assure competent public and personal health care workforce. 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services. 10. Research for new insights and innovative solutions to health problems.

Application to Policy

The term policy is often thought to be synonymous with legislation or judiciary action. However, policy broadly connotes an agreement on issues, goals, or a course of action by the people with the power to carry out policies and enforce them (Caplan, Ben-Moshe, & Dillon, 2013). But, who influences those with the power? Health in All Policies is a collective methodology to expand the health of all people by incorporating health considerations into decision-making activities within all sectors and policy areas (Caplan, Ben-Moshe, & Dillon, 2013). It is a framework that provides the backdrop to improve health outcomes and increase health equity through collaboration between public health practitioners and those nontraditional partners who influence the determinants of health. C/PHN are change agents practicing with a justice approach that is collaborative, promotes health and equity, and engages community gatekeepers and stakeholders in creating structural and procedural change benefiting both the population served and the health care delivery system. The C/PHN competencies set the stage for population-focused care that is inclusive of policies at all levels.

Application to Research

Research is a key component in establishing and continuing to develop the health care workforce to meet the challenges of 21st-century C/PHN services in the health care delivery system (Joyce et al., 2015). Research is the systematic investigation into and study of materials and sources to establish facts and reach new conclusions (Merriam Webster, 2018). The discovery and explanation of new knowledge gained through the use of community-based participatory research (*CBPR*) methodology is the basis for developing and sustaining systems that meet the needs of the populations served. Utilization of a standard data collection and information management system like the Omaha System (Martin, 2005) facilitates collaborative work and a common language for inter-professional practice (Joyce et al., 2015). C/PHN practice serves as an important model for the development, implementation, and evaluation of community-based programs to harness data and information that will affect meaningful community change.

Academic/practice/community partnerships must use a common language to scaffold collaborative work, such as *CBPR*. Leading and participating in *CBPR*, enhances C/PHN's visibility and value as a means to improve *population health*, the service delivery experience for individuals, families, groups and the community and reduce per capita costs (IHI, 2018).

More information about the PHN specialty is needed and who better than C/PHN to lead the charge. Heretofore, a study attempted to describe the enumeration and characterization of practicing C/PHNs (University of Michigan Center of Excellence in Public Health Workforce Studies, 2013). This study described the largest segment of the public health workforce by delineating their size, composition, educational/training background, and work roles and settings (UMCEPHWS, 2013). Also, a baseline demographic study

defined the population of academic/clinical faculty and ascertained the knowledge, skills, and attitudes of individual faculty related to the Quad Council Competencies for Public Health Nurses (2011) (Joyce et al., 2018). The further systematic investigation of the utilization of C/PHN competencies will continue to help us *benchmark* and frame C/PHN practice and education. Research can increase communication within the specialty and between professions, enhance inter-professional partnerships, provide a foundation to increase awareness of the competencies as they relate to *population health*, guide clinical practicum activities in undergraduate and graduate education, and evaluate population-focused work across education, practice, research, and policy development.

Definitions of Terms (italicized in the document)

Benchmarks - Utilized for performance management and quality improvement in C/PHN practice, education and research.

Community-Based Participatory Research (CBPR) - Combines traditional research methods with community capacity-building strategies to bridge the gap between knowledge produced through research and health care practices of the community. The community members are full partners with the researchers about the development and implementation of the study, analysis of the data, and dissemination of the findings. The essential benefit stemming from this collaboration is a deeper understanding of a community's needs (Savage, Yin, Lee, Rose, Kapesser, & Anthony, 2006). *Not to be confused with Community Based Research conducted with the community as the study setting.*

Competency – The combination of observable and measurable knowledge, skills, abilities and personal attributes that contribute to enhanced employee performance and ultimately result in organizational success.

Complex Decision Making – Complex decision making involves considering principles & values, collecting all available qualitative and quantitative data & information, group building, using system dynamics and multiple objective optimizations to support policy analysis and systemic decision making (Quadrat-Ullah, Spector & Davidsen, 2008).

Critical Behaviors – Aspects of a job which require the most attention and are powerful assets in the pursuit of career advancement.

Critical Thinking – Includes analyzing, applying standards, discrimination, information seeking, logical reasoning, predicting and transforming knowledge (Scheffer & Rubenfeld, 2000).

Ecological Perspective – “A conceptual framework designed to draw attention to the individual (i.e., social, genetic, behavior) and environmental (i.e., live, work, play, pray) determinants of [behavior]” (McLaren & Hawe, 2005, p.9).

Informatics – “The study and use of information processes and technology in the arts, sciences, and the professions” (Nelson & Staggers, 2014, p.512).

Information Technology – “The technology involving the development, maintenance, and use of computer systems, software, and networks for the process and distribution of data” (Merriam-Webster, 2018).

Population Health – “The health outcomes of a group of individuals, including the distribution of such outcomes within a group. The focus is on trying to understand the determinants of health of populations. The overall goal of a *population health* approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups” (Kindig & Stoddart, 2003 p. 380; Kindig, 2007).

Public Health Nursing – “The practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences. Public health nursing is a specialty practice within nursing and public health. It focuses on improving *population health* by emphasizing prevention and attending to multiple determinants of health. Often used interchangeably with community health nursing, this nursing practice includes advocacy, policy development, and planning, which addresses issues of social justice” (APHA PHN, 2013).

Public Health Nursing Diagnosis – Is the use of the nursing process within the context of placing the community or a population at the center of public health nursing practice. The focus shifts from an individual client to *individuals, families, groups, the community, or population.*

Referral – A process in which a healthcare worker has insufficient resources (i.e., drugs, equipment, skills) to manage a clinical condition. The health worker then seeks the assistance of a better or differently resourced facility at the same or higher level to assist in or take over the management of a client’s case (USAID, 2013, p. v).

Domain 1: Assessment and Analytic Skills Assessment/Analytic Skills focus on identifying and understanding data, turning data into information for action, assessing needs and assets to address community health needs, developing community health assessments, and using evidence for decision making.		
1A1. Assess the health status and health literacy of individuals and families, including determinants of health, using multiple sources of data.	1B1. Assess the health status and health literacy of populations and their related determinants of health across the lifespan and wellness continuum.	1C1. Apply appropriate comprehensive, in-depth system/organizational assessments and analyses as it relates to *population health*.
1A2a. Use an *ecological perspective* and epidemiological data to identify health risks for a population. 1A2b. Identify individual and family assets, needs, values, beliefs, resources and relevant environmental factors.	1B2. Develop *public health nursing diagnoses* and program implementation plans utilizing an *ecological perspective* and epidemiological data for individuals, families, communities, and populations.	1C2a. Apply organizational and other theories to guide the development of system-wide approaches to reduce population-level health risks. 1C2b. Design systems that identify population assets and resources and relevant social, economic, and environmental factors.
1A3. Select variables that measure health and public health conditions.	1B3. Use a comprehensive set of relevant variables within and across systems to measure health and public health conditions.	1C3. Adapt a comprehensive set of relevant variables within and across systems to measure health and public health conditions.
1A4. Use a data collection plan that incorporates valid and reliable methods and instruments for collection of qualitative and quantitative data to inform the service for individuals, families, and a community.	1B4. Use steps of program planning incorporating socio-behavioral and epidemiological models and principles to collect quality quantitative and qualitative data.	1C4a. Design systems that support the collection of valid and reliable quantitative and qualitative data on individuals, families, and populations. 1C4b. Design systems to improve and assure the optimal validity, reliability, and comparability of data.
1A5. Interpret valid and reliable data that impacts the health of individuals, families, and communities to make comparisons that are understandable to all who were involved in the assessment process.	1B5. Use multiple methods and sources of data for concise and comprehensive community/population assessment that can be documented and interpreted in terms that are understandable to all who were involved in the process, including communities.	1C5a. Design systems to assure that assessments are documented and interpreted in terms that are understandable to all partners/stakeholders. 1C5b. Design data collection system that uses multiple methods and sources when collecting and analyzing data to ensure a comprehensive assessment process.

Domain 1: Assessment and Analytic Skills (Continued)		
1A6. Compare appropriate data sources in a community.	1B6a. Address gaps and redundancies in data sources used in a comprehensive community/population assessment. 1B6b. Examine the effect of gaps in data on Public Health practice and program planning.	1C6a. Recognize gaps and redundancies in sources of data used in a comprehensive system/organizational assessment. 1C6b. Strategize plan with appropriate team members to address data gaps.
1A7. Contribute to comprehensive community health assessments through the application of quantitative and qualitative public health nursing data.	1B7a. Synthesize qualitative and quantitative data during data analysis for a comprehensive community/population assessment. 1B7b. Use various data collection methods and qualitative and quantitative data sources to conduct a comprehensive community/population assessment.	1C7a. Evaluate qualitative and quantitative data during data analysis for a comprehensive system/organizational assessment. 1C7b. Use multiple methods and qualitative and quantitative data sources for a comprehensive system/organizational assessment.
1A8. Apply ethical, legal, and policy guidelines and principles in the collection, maintenance, use, and dissemination of data and information.	1B8. Maximize the application of ethical, legal, and policy guidelines and principles in the collection, maintenance, use, and dissemination of data and information.	1C8a. Evaluate information disseminated to ensure it is understandable by the community and stakeholders 1C8b. Create systems that incorporate ethical, legal, and policy guidelines and principles into the collection, maintenance, use, and dissemination of data and information.
1A9. Use varied approaches in the identification of community needs (i.e., focus groups, multi-sector collaboration, SWOT analysis).	1B9. Assess the quality of various data collection methods used to conduct a comprehensive community/population assessment.	1C9. Evaluate the quality of various data collection methods used to conduct a comprehensive community/population or system/organizational assessment.
1A10. Use *information technology* effectively to collect, analyze, store, and retrieve data related to public health nursing services for individuals, families, and groups.	1B10. Identify *information technology* to effectively collect, analyze, store, and retrieve data related to planning and evaluating public health nursing services for communities and populations.	1C10a. Maximize *information technology* resources and collaboration with others in the design of data collection processes. 1C10b. Facilitate the collection, use, storage, and retrieval of data.

Domain 1: Assessment and Analytic Skills (Continued)		
1A11. Use evidence-based strategies or promising practices from across disciplines to promote health in communities and populations.	1B11a. Integrate current evidence-based strategies or promising practices that address scientific, political, ethical and social issues to promote improvement in health care systems and populations. 1B11b. Use evidence-based strategies or promising practices that address scientific, political, ethical, and social public health issues to create and modify systems of care.	1C11a. Evaluate evidence-based data, programs, and strategies or promising practices to create and modify systems of care and to support strategies that address scientific, political, ethical, and social public health issues. 1C11b. Promote research and evidence-based environments.
1A12. Use available data and resources related to the determinants of health when planning services for individuals, families, and groups.	1B12. Use data related to the determinants of health and community resources to plan for, analyze, and evaluate community-oriented and population-level programs.	1C12a. Evaluate organization/system capacity to analyze the health status of the community/population effectively. 1C12b. Determine the allocation of organization/system resources to support the effective analysis of the health status of the community/population.

Domain 2: Policy Development/Program Planning Skills Policy Development/Program Planning Skills focus on determining needed policies and programs; advocating for policies and programs; planning, implementing, and evaluating policies and programs; developing and implementing strategies for continuous quality improvement; and developing and implementing community health improvement plans and strategic plans.		
2A1. Identify local, state, national, and international policy issues relevant to the health of individuals, families, and groups.	2B1. Use valid and reliable data relevant to specific populations to support policies that improve health outcomes.	2C1. Design data collection methods and processes that inform public health policy creation and modification.
2A2. Describe the implications and potential impacts of public health programs and policies on individuals, families, and groups within a population.	2B2. Plan population-level interventions guided by policy, relevant models and research findings that impact communities and populations.	2C2. Evaluate complex policy options to plan public health services at the systems level.
2A3. Identify outcomes of health policy relevant to public health nursing practice for individuals, families, and groups.	2B3. Use policy analysis methods to align with public health nursing practice and public health issues.	2C3. Plan methods of policy analysis to address specific public health and systems issues and to influence public health nursing practice.
2A4a. Provide information that will inform policy decisions. 2A4b. Implement programs and services based on policy decisions.	2B4. Use existing concepts, models, theories, policy and evidence to plan, conduct and evaluate population-level interventions to address specific public health issues.	2C4. Use existing models and evidence to develop policies for public health systems within the framework (i.e., Board of Health, County Commissioners, City Council, Advisory Boards) of the organization's governing body.
2A5. Use organizations strategic plans and decision-making methods in the development of program goals and objectives for individuals, families, and groups.	2B5a. Select appropriate methods of decision analysis to address public health issues relevant to an identified group, community, or population. 2B5b. Use planning models, epidemiology, and other analytical methods in the development, implementation, and evaluation of population-level interventions.	2C5a. Create a system of decision analysis using the strengths and appropriateness of various policy models and methods. 2C5b. Evaluate health and public policy to address current and emerging public health problems and issues. 2C5c. Advocate for the role of public health in providing *population health* services.
2A6a. Demonstrate knowledge of laws and regulation relevant to public health nursing services. 2A6b. Plan public health nursing services consistent with laws and regulations.	2B6a. Analyze compliance with public health laws and regulations at the programmatic level. 2B6b. Assure compliance with public health laws and regulation in the planning and evaluation of community/population-based health services.	2C6a. Design public health programs and services consistent with laws and regulations. 2C6b. Justify public health programs and services to improve community/*population health*.

Domain 2: Policy Development/Program Planning Skills (Continued)		
2A7. Function as a team member in developing organizational plans while assuring compliance with established policies and program implementation guidelines.	2B7. Develop plans to implement programs and organizational policies through interprofessional teamwork to accomplish community/population level interventions.	2C7a. Implement a system(s) for monitoring the effectiveness and efficiency of policies and programs. 2C7b. Assume leadership of an interprofessional team to implement health policy in *population health* interventions and health systems operations.
2A8. Comply with organizational procedures and policies.	2B8. Manage programs in areas of responsibility while implementing organizational policies.	2C8. Administer the implementation of organizational policy throughout the organization.
2A9. Use program planning skills and *CBPR* (i.e., collaboration, reflection, capacity building) to implement strategies to engage marginalized/disadvantaged population groups in making decisions that affect their health and well-being.	2B9. Conduct an evaluation plan that includes process and outcome measures, multiple data collection methods, provides a feedback loop on programs and incorporates *information technology* for data collection, monitoring, and evaluation of service delivery to communities and populations.	2C9a. Evaluate overall effectiveness, quality, and sustainability of programs. 2C9b. Design systems-level quality initiatives and evaluation plans that foster program sustainability. 2C9c. Incorporate quality and cost measures for agency program evaluation. 2C9d. Identify resources that support quality improvement and program evaluation. 2C9e. Promote the use of technology to improve the evaluation of program quality and effectiveness.
2A10. Apply methods and practices to access public health information for individuals, families, and groups.	2B10a. Identify a variety of sources and methods to access public health information for community or population health program planning. 2B10b. Use technology to collect data to monitor and evaluate the quality and effectiveness of programs for populations.	2C10a. Recommend technologies for identification and use with communities and populations. 2C10b. Use technology to collect data to monitor and evaluate the quality and effectiveness of programs and systems.
2A11. Participate in quality improvement teams by using quality indicators and core measures to identify and address opportunities for improvement in services for individuals, families, and groups.	2B11. Develop quality improvement indicators and core measures as part of the process to enhance public health programs and services.	2C11. Adapt organizational and system-wide strategies for continuous quality improvement and performance management.

Domain 2: Policy Development/Program Planning Skills (Continued)		
2A10. Apply methods and practices to access public health information for individuals, families, and groups.	2B10a. Identify a variety of sources and methods to access public health information for community or population program planning. 2B10b. Use technology to collect data to monitor and evaluate the quality and effectiveness of programs for populations.	2C10a. Recommend technologies for identification and use with communities and populations. 2C10b. Use technology to collect data to monitor and evaluate the quality and effectiveness of programs and systems.
2A11. Participate in quality improvement teams by using quality indicators and core measures to identify and address opportunities for improvement in services for individuals, families, and groups.	2B11. Develop quality improvement indicators and core measures as part of the process to enhance public health programs and services.	2C11. Adapt organizational and system-wide strategies for continuous quality improvement and performance management.

Domain 3: Communication Skills

Communication Skills focus on assessing and addressing population literacy; soliciting and using community input; communicating data and information; facilitating communications; and communicating the roles of government, health care, and others.

3A1. Determine the health, literacy, and the health literacy of the population served to guide health promotion and disease prevention activities.	3B1. Design health promotion and disease prevention educational programs based upon the literacy level of the population served.	3C1. Adapt health literacy principles into all organizational communications to support the needs of resources of those receiving health information.
3A2. Apply *critical thinking* and cultural awareness to all communication modes (i.e., verbal, non-verbal, written & electronic) with individuals, the community, and stakeholders.	3B2. Use critical thinking and *complex decision making* in all communication modes with the community, organizations, stakeholders, and funders.	3C2. Communicate critical thinking and *complex decision making* at the systems level utilizing all types of communication modes.
3A3. Use input from individuals, families, and groups when planning and delivering health care programs and services.	3B3. Evaluate input from community /population members and stakeholders when planning health care programs and services.	3C3. Design strategies to solicit and evaluate input from diverse organizational partners, stakeholders, vulnerable and marginalized populations when planning health care programs and services.
3A4. Use a variety of methods to disseminate public health information to individuals, families, and groups within a population.	3B4. Maximize a variety of methods to disseminate public health information tailored to communities/ populations.	3C4. Use systems level methods, based on appropriate literacy level to varying audiences, to widely disseminate public health information, influence behavior, and improve health.
3A5a. Create a presentation of targeted health information. 3A5b. Communicate information to multiple audiences including groups, peer professionals, and agency peers.	3B5. Evaluate the effectiveness of presentations of targeted health information to multiple audiences, including community and professional groups.	3C5a. Model presentation of targeted health information to multiple audiences, as well as to a variety of organizations. 3C5b. Support other public health professionals as they develop presentation/dissemination skills.

Domain 3: Communication Skills (Continued)		
3A6. Use communication models to communicate with individuals, families, and groups effectively and as a member of the interprofessional team(s) or interdisciplinary partnerships.	3B6. Determine effective communication with community, groups, interdisciplinary partners, and inter-professional teams.	3C6a. Maximize effective communication with systems leaders and key stakeholders 3C6b. Model effective communications as member or leader of inter-professional teams and interdisciplinary partnerships, both internally and externally.
3A7. Describe the role of public health nursing to internal and external audiences.	3B7. Summarize the role of public health and public health nursing within the overall health system to internal and external audiences.	3C7. Evaluate system/organizational capacity to articulate and support the expansive roles of public health nurses and public health.
3A8. Apply communication techniques and models when interacting with peers and other healthcare team members including conflict management.	3B8. Support communication techniques and models when interacting with peers and other healthcare team members including conflict management.	3C8a. Apply communication techniques and models to managing staff, motivating personnel, and resolving conflicts within the organization/system 3C8b. Generate communication policies and procedures that support conflict management throughout the organization/system.

Domain 4: Cultural Competency Skills

Cultural Competency Skills focus on understanding and responding to diverse needs, assessing organizational cultural diversity and competence, assessing effects of policies and programs on different populations, and taking action to support a diverse public health workforce.

4A1. Use determinants of health effectively when working with diverse individuals, families, and groups.	4B1. Apply determinants of health to develop culturally responsive interventions with communities and populations.	4C1a. Assure recognition and respect for diversity in the organizational structure. 4C1b. Support the dynamic nature of a diverse workforce and the necessity for on-going responsiveness to the changing needs of diverse populations.
4A2. Use data, evidence and *information technology* to understand the impact of determinants of health on individuals, families, and groups.	4B2a. Use epidemiological data, concepts, and other evidence to analyze the determinants of health when developing and tailoring population-level health services. 4B2b. Apply multiple methods and sources of *information technology* to understand better the impact of the determinants of health has on communities and populations.	4C2a. Develop systems-level health programs using knowledge of determinants of health. 4C2b. Support the use of *CBPR* and other methods to measure and evaluate the effectiveness of population-level health services and programs, strategies for reducing the impact of determinants of health. 4C2c. Prioritize access to technology that provides information in determining the delivery of public health services (i.e., cultural, social, economic, environmental & behavioral factors).
4A3. Deliver culturally responsive public health nursing services for individuals, families, and groups.	4B3a. Plan for health services delivery that integrates cultural perceptions of health and disease and addresses the needs of culturally diverse populations. 4B3b. Use evidence-based models or promising practices to enhance the organization's cultural competence. 4B3c. Evaluate organizational/system adherence to standards, policies, and practices for cultural competence.	4C3. Determine the effectiveness of culturally responsive public health services at the systems level.

Domain 4: Cultural Competency Skills (Continued)		
4A4. Explain the benefits of a diverse public health workforce that supports a just and civil culture.	4B4. Advocate building a diverse public health workforce that supports a just and civil culture.	4C4. Create actions that foster a diverse public health workforce that supports a just and civil culture.
4A5. Demonstrate the use of evidence-based cultural models in a work environment when providing services to individuals, families, and groups.	4B5a. Use cultural models and evidence to tailor and evaluate interventions and programs for diverse populations. 4B5b. Evaluate staff development needs related to cultural diversity.	4C5a. Use evidence-based models to enhance the organization’s cultural competence. 4C5b. Evaluate organizational/system processes for adherence to standards, policies, and practices for cultural competence.

Domain 5: Community Dimensions of Practice Skills

Community Dimensions of Practice Skills focus on evaluating and developing linkages and relationships within the community, maintaining and advancing partnerships and community involvement, negotiating for the use of community assets, defending public health policies and programs, and evaluating & improving the effectiveness of community engagement.

5A1a. Use assessments, develops plans, implements, and evaluates interventions for public health services for individuals, families and groups. 5A1b. Assist individuals, families, and groups to identify and access necessary community resources or services through the *referral* and follow-up process.	5B1. Use a systematic process to direct assessments, plans, interventions, and evaluations of public health services for communities, populations, and programs.	5C1. Use community linkages and inter-professional relationships within and across organizations and systems to communicate results of assessments, proposed plans, interventions, and evaluations of public health services.
5A2. Use formal and informal relational networks among community organizations and systems conducive to improving the health of individuals, families, and groups within communities.	5B2. Use formal and informal relational networks among community organizations and systems conducive to improving the health within programs, communities, and populations.	5C2. Create internal and external organizational relationships, processes, and system improvements to enhance the health of populations.
5A3a. Select stakeholders needed to address public health issues impacting the health of individuals, families, and groups within the community. 5A3b. Function effectively with key stakeholders in activities that facilitate community involvement and delivery of services to individuals, families, and groups.	5B3a. Organize stakeholders required to create community groups/coalitions in the community to address public health issues impacting *population health*. 5B3b. Function effectively with key stakeholders and groups in activities that facilitate community involvement and delivery of services to communities, populations, and programs.	5C3a. Create strategies that enhance collaboration within and across systems and organizations to address *population health* issues. 5C3b. Maximize collaboration with key stakeholders and groups within and across systems and organizations to enhance the health of a population. 5C3c. Evaluate the effectiveness of collaborative relationships and partnerships within organizations and systems.

Domain 5: Community Dimensions of Practice Skills (Continued)		
5A4. Build stakeholder capacity to advocate for the health issues of individuals, families, and groups.	54Ba. Utilize effective partnerships with key stakeholders and groups to promote health within programs, communities, and populations. 54Bb. Interpret the role of government and the private and non-profit sectors in the delivery of community health services to community groups and partners.	5C4a. Formulate strategies (including documentation) for ongoing and meaningful community involvement in activities addressing *population health* issues within and across systems and organizations. 5C4b. Influence the role of government, the private sector, and non-profit sectors in the delivery of community health services.
5A5. Use community assets and resources, including the government, private, and non-profit sectors, to promote health and to deliver services to individuals, families, and groups.	5B5. Use community assets and resources, including those of government, private, and non-profit sectors, to promote health within programs, communities, and populations.	5C5. Develop community assets and resources, including seeking needed resources, to improve the health status of communities and populations health issues within and across systems and organizations.
5A6. Use input from varied sources to structure public health programs and services for individuals, families, and groups.	5B6. Use input from a variety of community and aggregate stakeholders in the development of public health programs and services for communities and populations.	5C6. Maximize the inclusion of input from the communities served when developing public health policies, programs, and services.
5A7a. Interview individuals, families, and groups to identify community resource preferences. 5A7b. Build preferences into public health services. 5A7c. Identify opportunities for individuals, families, and groups to link with advocacy organizations.	5B7. Assume leadership in advocacy efforts for public health policies, programs, and resources that enhance services to communities and populations.	5C7a. Influence policies, programs, and resources within and between organizations and systems that improve health in a community or population. 5C7b. Influence public health priorities that improve *population health* and impact healthcare systems through leadership and advocacy efforts.
5A8. Identify evidence of the effectiveness of community engagement strategies on individuals, families, and groups.	5B8. Evaluate the effectiveness of community engagement strategies on communities and populations.	5C8. Appraise the effectiveness of community engagement strategies on public health policies, programs, services, and resources.

Domain 6: Public Health Sciences Skills Public Health Sciences Skills focus on understanding the foundation and prominent events of public health, applying public sciences to practice, critiquing and developing research, using evidence when developing policies and programs, and establishing academic partnerships.		
6A1. Use the determinants of health and evidence-based practices from public health and nursing science, when planning health promotion & disease prevention interventions for individuals, families, and groups.	6B1. Use public health and nursing science in practice at community and populations level.	6C1. Use expertise in public health and nursing sciences in the design of public health nursing programs and practice environments.
6A2a. Determine the relationship between access to clean, sustainable water, sanitation, food, air, and energy quality on individual, family, and *population health*. 6A2b. Assess hazards and threats to individuals, families, and populations and reduce their risk of exposure and injury in natural and built environments (i.e., chemicals and products).	6B2a. Maximize community partnerships that support clean, sustainable water, sanitation, food, air, and energy quality of the community. 6B2b. Identify hazards and threats to communities and reduce the risk of exposure and injury in natural and built environments (i.e., chemicals and products).	6C2a. Maximize organizational programs that ensure access to clean water, sanitation, food, air, and energy quality of the community. 6C2b. Plan interventions that address hazards and threats to communities and reduce the risk of exposure and injury in natural and built environments (i.e., chemicals and products).
6A3. Use evidence-based practice in population-level programs to contribute to meeting core public health functions and the 10 essential public health services.	6B3. Analyze contribution of evidence-based practice in population-level programs in meeting core public health functions and the 10 essential public health services.	6C3. Appraise organization's contribution to meeting the core public health functions and the 10 essential public health services using epidemiology and other methods.
6A4. Participate in research activities impacting the health of populations.	6B4a. Support research across disciplines related to public health priorities and population-level interventions. 6B4b. Support research activities within the organization.	6C4a. Maximize organizational effectiveness by translating research into practice. 6C4b. Assure programs and policies are based on current research and evidence-based practice.

Domain 6: Public Health Sciences Skills (Continued)		
6A5. Use a wide variety of sources and methods to access public health information (i.e., GIS mapping, Community Health Assessment, local/state/and national sources).	6B5. Examine gaps in public health *informatics* related to public health priorities and population-level interventions.	6C5. Support, as an expert resource for others, the identification and use of public health *informatics*.
6A6a. Use research to inform the practice of public health nursing. 6A6b. Identify gaps in research evidence that impacts public health nursing practice	6B6a. Examine gaps and inconsistencies in research evidence for practice 6B6b. Choose peer-reviewed journals and national-level meetings for dissemination of theory-guided and evidence-based practice outcomes.	6C6a. Plan with academic partners, internal and external stakeholders, and other public health professionals to address limitations of research findings. 6C6b. Develop new approaches to theory-guided and evidence-based practice in public health. 6C6c. Evaluate theory-guided and evidence-based practice in public health. 6C6d. Decide dissemination methods of new evidence-based practices in public health.
6A7. Demonstrate compliance with the requirements of patient confidentiality and human subject protection.	6B7. Apply the requirements of patient confidentiality, human subject protection, and research ethics into data collection and processing.	6C7. Support, as an expert, the design of data collection methods that incorporate the requirements of patient confidentiality, human subject protection, and research ethics.
6A8. Model public health science skills when working with individuals, families, and groups.	6B8. Support acquisition and integration of public health science skills.	68C. Create partnerships with academic and other organizations to expand the public health science base and disseminate research findings.

Domain 7: Financial Planning, Evaluation, and Management Skills

Financial Planning and Management Skills focus on engaging other government agencies that can address community health needs, leveraging public health and health care funding mechanisms, developing and defending budgets, motivating personnel, evaluating and improving program and organization performance, and establishing and using performance management systems to improve organization performance.

7A1. Explain the interrelationships among local, state, tribal, and federal public health and healthcare systems.	7B1a. Provide leadership for the coordination of health programs. 7B1b. Maximize implementation of judicial and operational health programs within federal, state, tribal, and local public health agencies. 7B1c. Develop collaborations with relevant public and private systems for managing programs in public health.	7C1a. Develop health programs within federal, state, tribal, and local public health agencies. 7C1b. Identify potential funding sources and support to meet community and *population health* needs. 7C1c. Use relationships to form alliances across public and private healthcare systems that advance *population health*.
7A2. Explain the public health nurse's role in emergency preparedness and disaster response during public health events (i.e., infectious disease outbreak, natural or made-made disasters).	7B2. Develop partnerships with communities and agencies within the federal, state, tribal, and local levels of government that have authority over public health situations, such as emergency preparedness.	7C2. Demonstrate leadership across agency partnerships within the federal, state, tribal, and local levels of government that have authority over public health situations or with specific issues, such as emergency events.
7A3. Implement operational procedures for public health programs and services.	7B3. Translate statutes and operational procedures of governing bodies and administrative units designated for oversight of public health organizational operations.	7C3. Prioritize the implementation of statues and operational procedures of the governing bodies and administrative unit designated with oversight of public health organizational operations.
7A4a. Demonstrate knowledge of funding streams to support programs. 7A4b. Select the data for inclusion in a programmatic budget.	7B4a. Develop strategies for determining programmatic budget priorities based on program outcomes, stakeholder, cost-analysis & financial input from federal, state, tribal, and local sources. 7B4b. Develop a programmatic budget using available data. 7B4c. Monitor budgets based on program requirements.	7C4a. Recommend strategies for determining budget priorities. 7C4b. Develop an organization-wide budget to provide resources to meet the needs of patient, family, community to achieve desired outcomes.

Domain 7: Financial Planning, Evaluation, and Management Skills (Continued)		
7A5. Interpret the impact of budget constraints on the delivery of public health nursing services to individuals, families, and groups.	7B5. Adapt delivery of services to communities/populations within current and forecasted budget constraints.	7C5. Manage the delivery of agency services within current and forecasted budget constraints.
7A6. Explain implications of organizational budget priorities on individual, groups, and communities.	7B6. Develop strategies for determining budget priorities based on financial input from federal, state, tribal, and local sources.	7C6. Defends an organization-wide budget to provide resources to improve *population health*.
7A7. Explain public health nursing services and programmatic needs to inform budget priorities.	7B7a. Assess the impact of organizational budget priorities on public health nursing programs and services based on historical data and outcomes. 7B7b. Establish organizational public health nursing resources that assure effective services.	7C7. Evaluate the impact of organizational budget priorities on practice and public health systems.
7A8a. Identify data to evaluate services for individuals, families, and groups. 7A8b. Contribute to the evaluation plan for public health nursing services targeting individuals, families, and groups.	7B8. Design implementation and evaluation plans for population-focused programs.	7C8. Use evaluation results of population-focused programs at the organizational level for quality, effectiveness, efficiency, safety, and sustainability.
7A9. Deliver public health nursing services to individuals, families, and groups based on reported evaluation results.	7B9a. Examine revisions to population-focused programs and services based on formative process and summative evaluation results. 7B9b. Use continuous quality improvement models when managing operational and programmatic change.	7C9. Develop evaluation systems about change strategies.
7A10. Provide input into the fiscal and narrative components of proposals.	7B10a. Develop detailed project proposals and reports for grants and other outside funding sources. 7B10b. Appraise external sources of funding proposals.	7C10a. Select proposals for submission to external funding sources and monitors through the implementation of appropriate financial management systems. 7C10b. Ensure accurate accounting of transactions supported by source documents to establish a sound track record for future funding opportunities.

Domain 7: Financial Planning, Evaluation, and Management Skills (Continued)		
7A11. Use public health *informatics* skills pertaining to public health nursing services of individuals, families & groups.	7B11. Identify opportunities to use public health *informatics* skills to improve public health programs and business operations.	7C11a. Design system-wide utilization of public health *informatics*. 7C11b. Prioritize system-wide uptake of public health *informatics*.
7A12. Provide input for contracts and other agreements for the provision of public health services.	7B12. Develop contracts and other agreements for the provision of public health services.	7C12. Prioritize and approves contracts and other agreements for the provision of public health services.
7A13. Organize public health nursing services and programs for individuals, families, and groups within budgetary guidelines.	7B13a. Determine which fiscal management technique (i.e., cost-effectiveness, cost-benefit, cost-utility, return on investment or risk management analysis) applies to public health nursing services and programs. 7B13b. Apply fiscal management techniques for programmatic prioritization and decision making.	7C13. Evaluate available financial analyses in decision making and prioritizing programs across organizations and systems.
7A14a. Participate in the implementation of the organization's performance management system. 7A14b. Use self-reflection to identify one's performance in the organization's performance management system. 7A14c. List contributions to the organization's performance management system.	7B14a. Utilize data and information to improve organizational processes and performance. 7B14b. Use self-reflection to identify strategies to support others' contributions to the organization's performance management system.	7C14a. Establish a performance management system. 7C14b. Use self-reflection and insights gained to inform performance management improvement at the organizational and or systems level.

Domain 8: Leadership and Systems Thinking Skills

Leadership and Systems Thinking Skills focus on incorporating ethical standards into the organization; creating opportunities for collaboration among public health, healthcare, and other organizations; mentoring personnel; adjusting practice to address changing needs and environment; ensuring continuous quality improvement; managing organizational change; and advocating for the role of governmental public health.

8A1. Demonstrate ethical standards of practice in all aspects of public health and public health nursing as the basis of all interactions with individuals, communities, and organizations.	8B1a. Interpret public health and public health nursing ethical issues related to the public health nursing services of communities and populations. 8B1b. Recommend a course of action in response to identified ethical issues.	8C1a. Use ethical standards of practice as the basis of all interactions with organizations, communities, and individuals. 8C1b. Influence the adherence to public health and public health nursing ethical standards in all interactions with individuals, communities, and organizations.
8A2. Apply systems thinking to public health nursing practice with individuals, families, and groups.	8B2. Apply system thinking to public health nursing practice with communities and populations.	8C2a. Evaluate new approaches to public health practice that integrate organizational and systems thinking. 8C2b. Propose innovations in public health practice that integrate organizational and systems thinking.
8A3. Participate in stakeholder meetings to identify a shared vision, values, and principles for community action.	8B3. Influence team and community partners in identifying a shared vision, values, and principles for community action.	8C3a. Create meaningful opportunities for partnerships with stakeholders to determine key values and shared vision as guiding principles for community action. 8C3b. Make use of a shared vision, values, and principles across the organization and healthcare system for community action.

Domain 8: Leadership and Systems Thinking Skills (Continued)		
8A4a. Identify internal and external factors affecting public health nursing practice and opportunities for interprofessional collaboration. 8A4b. Explain environmental hazards and emergency preparedness to protect individuals, families, and groups. 8A4c. Respond to environmental hazards to protect individuals, families, and groups.	8B4a. Analyze internal and external factors that may impact the delivery of essential public health services. 8B4b. Assure quality and coordination in the delivery of public health nursing services. 8B4c. Demonstrate capacity to determine community public health emergency preparedness needs and organize response activities.	8C4a. Design strategies that address internal and external factors that impact the delivery of essential public health services. 8C4b. Use systems that assure quality, collaboration, and coordination in the delivery of essential public health services. 8C4c. Build functional capabilities of public health emergency preparedness across community sectors.
8A5. Use individual, team, and organizational learning opportunities for personal and professional development as a public health nurse.	8B5. Determine inter-professional team and organizational learning opportunities to encourage ongoing staff development.	8C5. Support development of learning opportunities at the levels of individual, inter-professional team, and organization.
8A6. Model personal commitment to lifelong learning, professional development, and advocacy.	8B6. Determine opportunities to mentor, advice, coach, and develop peers, direct reports, and other members of the public health workforce.	8C6. Create opportunities for mentoring, peer advising, coaching, and professional development systems for the public health workforce.
8A7. Identify organizational quality improvement initiatives that provide opportunities for improvement in public health nursing practice.	8B7a. Use evidence-based models to design and implement quality initiatives. 8B7b. Monitor programmatic performance.	8C7a. Design systems to measure, report, and improve quality of services and organizational performance. 8C7b. Maintain systems to measure, report, and improve quality of services and organizational performance.
8A8. Facilitate the development of interprofessional teams and workgroups.	8B8. Develop interprofessional team-oriented structures and systems to advance organizational mission and vision.	8C8. Adapt organizational infrastructure and implement system changes to facilitate interprofessional team development.

Domain 8: Leadership and Systems Thinking Skills (Continued)		
8A9. Interpret organization dynamics of collaborating agencies.	8B9. Influence identification of shared and complementary mission and vision.	8C9a. Function as chief public health strategist, assuring that all relevant partners work in collaboration to drive prevention initiatives. 8C9b. Create common-values based approach with ethical standards across systems.
8A10a. Provide feedback on the organization's mission and vision and the impact on individuals, families, and groups. 8A10b. Influence others to provide feedback on the organization's mission and vision and the impact on individuals, families, and groups.	8B10. Influence the reassessment and adaptation of mission and vision.	8C10. Facilitate strategies that reassess the organization's mission and vision and adaptation within the system.
8A11. Select advocacy strategies to address the needs of diverse and underserved population.	8B11. Determine key stakeholders (i.e., political, community, informal and informal leaders, and funders/donors) and resources necessary for collective impact on improving the health of diverse and underserved populations.	8C11a. Evaluate strategies to achieve national, state and local health goals and objectives. 8C11b. Create advocacy strategies at the organizational and systems levels to address the health of populations.
8A12. Identify organizational policies and procedures that meet practice and public health accreditation requirements.	8B12. Analyze evidence demonstrating adherence to public health accreditation and practice standards in program planning and evaluation, staff development, interprofessional teamwork, and other organizational activities.	8C12. Create policies, processes, and systems within the organization to maintain standards in practice and accreditation.
8A13. Influence health as a shared value through community engagement and inclusion of individuals, families, and groups.	8B13. Influence health as a shared value through community engagement and inclusion of communities and populations.	8C13. Influence health as a shared value through community engagement at the organizational and systems level.

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Appendix A

C/PHN Competency Evaluation Tool

Introduction

This evaluation tool has been developed as a template to apply Tier 1 C/PHN competencies to practice & education and for stimulating research activities. Critical behaviors for each Domain have been identified but only as an example to enhance initial use and stimulate related activities as policy development, research activities, and educational initiatives. The committee only identified six competencies as critical behaviors for each Domain. Extra competencies may be added to reflect specific job descriptions as desired or the tool may be adapted to fit the needs of the organization. An additional optional section was developed related to professional behavior, which may also be adapted as desired.

Name ____ ☐ Formative ☐ Summative

Directions: Rate each practice objective using the following scale:

- **Satisfactory (S):** Safe performance, demonstrates expected skills, and application of nursing principles.
- **Needs Improvement (NI):** Does not consistently perform at a satisfactory level in practice behavior.
- **Unsatisfactory (U):** Performance is inadequate, indicates lack of skill, unsafe nursing practice, inadequate depth of knowledge, or application of nursing principles. Functions below expectations of a nurse at this level.

CLINICAL OBJECTIVE	RATING	EXAMPLES TO SUPPORT RATING
I. Assessment Analytic Skills:		
1. Assess the health status and health literacy of individuals and families, including determinants of health, using multiple sources of data. (1A1)	☐ **S** ☐ **NI** ☐ **U**	
2. Use an ecological perspective and epidemiological data to identify health risks for a population. (1A2a)	☐ **S** ☐ **NI** ☐ **U**	
3. Interpret valid and reliable data that impacts the health of individuals, families, and communities to make comparisons that are understandable to all who were involved in the assessment process. (1A5)	☐ **S** ☐ **NI** ☐ **U**	
4. Contribute to comprehensive community health assessments through the application of quantitative and qualitative public health nursing data. (1A7)	☐ **S** ☐ **NI** ☐ **U**	
5. Apply ethical, legal, and policy guidelines and principles in the collection, maintenance, use, and dissemination of data and information. (1A8)	☐ **S** ☐ **NI** ☐ **U**	
6. Use evidence-based strategies or promising practices from across disciplines to promote health in communities and populations. (1A11)	☐ **S** ☐ **NI** ☐ **U**	
II. Policy Development and Program Planning Skills:		
1. Describe the implications and potential impacts of public health programs and policies on individuals, families, and groups within a population. (2A2)	☐ **S** ☐ **NI** ☐ **U**	
2. Use organizations strategic plans and decision-making methods in the development of program goals and objectives for individuals, families, and groups. (2A5).	☐ **S** ☐ **NI** ☐ **U**	
3. Plan public health nursing services consistent with laws and regulations. (2A6b)	☐ **S** ☐ **NI** ☐ **U**	

11. Function as a team member in developing organizational plans while assuring compliance with established policies and program implementation guidelines. (2A7)	☐ **S** ☐ **NI** ☐ **U**	
12. Comply with organizational procedures and policies. (2A8)	☐ **S** ☐ **NI** ☐ **U**	
13. Use program planning skills and *CBPR* (i.e., collaboration, reflection, capacity building) to implement strategies to engage marginalized/disadvantaged population groups in making decisions that affect their health and well-being. (2A9)	☐ **S** ☐ **NI** ☐ **U**	
III. Communication Skills:		
1. Determine the health, literacy, and the health literacy of the population served to guide health promotion and disease prevention activities. (3A1)	☐ **S** ☐ **NI** ☐ **U**	
2. Apply critical thinking and cultural awareness to all communication modes (i.e., verbal, non-verbal, written & electronic) with individuals, the community, and stakeholders. (3A2)	☐ **S** ☐ **NI** ☐ **U**	
3. Use input from individuals, families, and groups when planning and delivering health care programs and services. (3A3)	☐ **S** ☐ **NI** ☐ **U**	
4. Use a variety of methods to disseminate public health information to individuals, families, and groups within a population. (3A4)	☐ **S** ☐ **NI** ☐ **U**	
5. Create a presentation of targeted health information. Communicate information to multiple audiences including groups, peer professionals, and agency peers. (3A5a & b)	☐ **S** ☐ **NI** ☐ **U**	
6. Use communication models to communicate with individuals, families, and groups effectively and as a member of the interprofessional team(s) or interdisciplinary partnerships. (3A6)	☐ **S** ☐ **NI** ☐ **U**	
IV. Cultural Competency Skills:		
1. Use determinants of health effectively when working with diverse individuals, families, and groups. (4A1)	☐ **S** ☐ **NI**	

	☐ U	
2. Deliver culturally responsive public health nursing services for individuals, families, and groups. (4A3)	☐ S ☐ NI ☐ U	
3. Demonstrate the use of evidence-based cultural models in a work environment when providing services to individuals, families, and groups. (4A5)	☐ S ☐ NI ☐ U	
V. Community Dimensions of Practice Skills:		
1. Use formal and informal relational networks among community organizations and systems conducive to improving the health of individuals, families, and groups within communities. (5A2)	☐ S ☐ NI ☐ U	
2. Select stakeholders needed to address public health issues impacting the health of individuals, families, and groups within the community. (5A3a)	☐ S ☐ NI ☐ U	
3. Use community assets and resources, including the government, private, and non-profit sectors, to promote health and to deliver services to individuals, families, and groups. (5A5)	☐ S ☐ NI ☐ U	
4. Use input from varied sources to structure public health programs and services for individuals, families, and groups. (5A6)	☐ S ☐ NI ☐ U	
5. Identify evidence of the effectiveness of community engagement strategies on individuals, families, and groups. (5A8)	☐ S ☐ NI ☐ U	
VI. Public Health Sciences Skills:		
1. Use the determinants of health and evidence-based practices from public health and nursing science, when planning health promotion & disease prevention interventions for individuals, families, and groups. (6A1)	☐ S ☐ NI ☐ U	
2. Assess hazards and threats to individuals, families, and populations and reduce their risk of exposure and injury in natural and built environments (i.e., chemicals and products). (6A2b)	☐ S ☐ NI ☐ U	

3. Use evidence-based practice in population-level programs to contribute to meeting core public health functions and the 10 essential public health services. (6A3)	☐ **S** ☐ **NI** ☐ **U**	
4. Use a wide variety of sources and methods to access public health information (i.e., GIS mapping, Community Health Assessment, local/state/and national sources). (6A5)	☐ **S** ☐ **NI** ☐ **U**	
5. Use research to inform the practice of public health nursing. (6A6a)	☐ **S** ☐ **NI** ☐ **U**	
6. Demonstrate compliance with the requirements of patient confidentiality and human subject protection. (6A7)	☐ **S** ☐ **NI** ☐ **U**	
VII. Financial Planning and Management and Planning Skills:		
1. Explain the public health nurse's role in emergency preparedness and disaster response during public health events (i.e., infectious disease outbreak, natural or made-made disasters). (7A2)	☐ **S** ☐ **NI** ☐ **U**	
2. Interpret the impact of budget constraints on the delivery of public health nursing services to individuals, families, and groups. (7A5)	☐ **S** ☐ **NI** ☐ **U**	
3. Explain implications of organizational budget priorities on individual, groups, and communities. (7A6)	☐ **S** ☐ **NI** ☐ **U**	
4. Explain public health nursing services and programmatic needs to inform budget priorities. (7A7)	☐ **S** ☐ **NI** ☐ **U**	
5. Identify data to evaluate services for individuals, families, and groups. (7A8a)	☐ **S** ☐ **NI** ☐ **U**	
6. Use public health informatics skills pertaining to public health nursing services of individuals, families & groups. (7A11)	☐ **S** ☐ **NI** ☐ **U**	

VIII. Leadership and Systems Thinking Skills:		
1. Demonstrate ethical standards of practice in all aspects of public health and public health nursing as the basis of all interactions with individuals, communities, and organizations. (8A1)	☐ **S** ☐ **NI** ☐ **U**	
2. Apply systems thinking to public health nursing practice with individuals, families, and groups. (8A2)	☐ **S** ☐ **NI** ☐ **U**	
3. Participate in stakeholder meetings to identify a shared vision, values, and principles for community action. (8A3)	☐ **S** ☐ **NI** ☐ **U**	
4. Identify internal and external factors affecting public health nursing practice and opportunities for interprofessional collaboration. (8A4a)	☐ **S** ☐ **NI** ☐ **U**	
5. Model personal commitment to lifelong learning, professional development, and advocacy. (8A6)	☐ **S** ☐ **NI** ☐ **U**	
6. Facilitate the development of interprofessional teams and workgroups. (8A8)	☐ **S** ☐ **NI** ☐ **U**	

Professional Conduct:		
1. Demonstrate professional accountability in the practice setting.	☐ **S** ☐ **NI** ☐ **U**	
2. Demonstrate willingness and ability to care for individuals, families, and communities.	☐ **S** ☐ **NI** ☐ **U**	

3. Arrive to practice on time and fully prepared.	☐ **S** ☐ **NI** ☐ **U**	
4. Strictly adhere to professional nursing standards of confidentiality, ethical principles and practice, and communication.	☐ **S** ☐ **NI** ☐ **U**	
5. Maintain a professional appearance at all times.	☐ **S** ☐ **NI** ☐ **U**	
6. Exhibit evidence-based practice in the clinical area.	☐ **S** ☐ **NI** ☐ **U**	
7. Demonstrate proficiency in basic nursing skills (vital signs, physical assessment, environmental assessment, communication, hand-offs).	☐ **S** ☐ **NI** ☐ **U**	
8. Works cooperatively within and without the practice team.	☐ **S** ☐ **NI** ☐ **U**	
9. Accepts constructive feedback from practice supervisor, agency staff, and peer group members.	☐ **S** ☐ **NI** ☐ **U**	
10. Actively engages in joint projects by meeting all group commitments.	☐ **S** ☐ **NI** ☐ **U**	
11. Consistently follows direction of practice supervisor and/or agency staff.	☐ **S** ☐ **NI** ☐ **U**	
12. Consistently demonstrates the ability to reflect on individual and professional strengths, role, and scope of practice.	☐ **S** ☐ **NI** ☐ **U**	
13. Seeks/uses/provides advice and consultation when needed.	☐ **S**	

	☐ **NI** ☐ **U**	
14. Consistently establishes inter- and/or intraprofessional contacts.	☐ **S** ☐ **NI** ☐ **U**	
15. Contributes ideas to the care planning of colleagues.	☐ **S** ☐ **NI** ☐ **U**	
16. Works effectively within the interprofessional team.	☐ **S** ☐ **NI** ☐ **U**	

Supervisor Signature: ___________________________________ Date: ___________________

Nurse Signature: _____________________________________ Date: __________________

Joyce, B.L., Harmon, M.J., Collinge, R., Brown-Schott, N., Johnson, R.H., Hicks, V.L., & Pilling, L.B. (in review).

6. Academic Health Department Learning Community:

- **Academic Health Department Learning Community Report**
- **Staged Model of AHD Development (Draft)**

Academic Health Department Learning Community Report

July 16, 2018

Overview

The Academic Health Department (AHD) Learning Community supports development of AHD partnerships between health departments and academic institutions. As a national community of practitioners, educators, and researchers, the AHD Learning Community stimulates discussion and sharing of knowledge; the development of resources; and collaborative learning around establishing, sustaining, and expanding AHD partnerships. Since its launch in 2011, the Learning Community has grown to more than 900 members and has continued to expand the resources and activities offered to these members and others in the public health community.

AHD Webinar Series and Ask the AHD Expert Column

Earlier this year, the AHD Learning Community transitioned its virtual meetings to an *AHD Webinar Series*. This webinar series is being held quarterly and will continue to highlight successful AHD partnerships and other topics of interest to individuals developing, sustaining, and expanding AHD partnerships. The first two webinars of 2018 focused on how AHD partnerships can support Public Health Accreditation Board and Council on Education for Public Health accreditation and building AHD partnerships in rural areas. All webinars in this series are archived and made available through the Council on Linkages Between Academia and Public Health Practice (Council) website and the TRAIN Learning Network. The AHD Learning Community also continues its quarterly *Ask the AHD Expert* column on the PHF Pulse blog. Now up to six columns, the latest column in this series focuses on how AHDs are engaging a variety of partners to impact community health.

Staged Model of AHD Development

Building on the working AHD concept paper developed by the Council in 2010 to provide a definition for AHD partnership and experiences shared by AHD Learning Community members, in 2017, a staged model of AHD development was drafted to illustrate how such partnerships may develop. This draft model was made available for public comment, and revisions are being made based on feedback received. The current draft of the model is included in the meeting materials. Version 1 of this model is expected to be available this summer, and an effort to capture stories of AHD partnerships that highlight different stages in the model will begin.

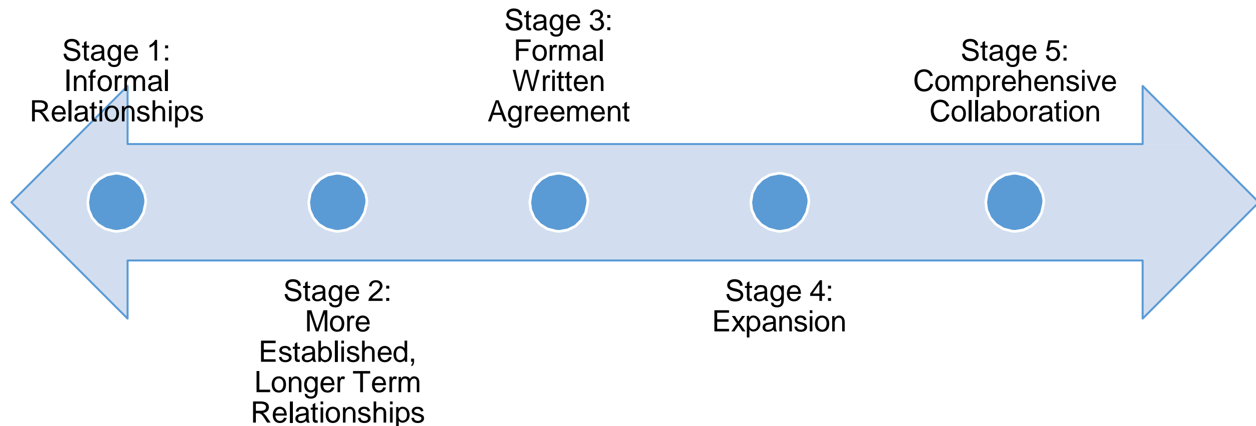
AHD Mentorship Program

The AHD Mentorship Program aims to foster the development, maintenance, and expansion of AHDs by building ongoing mentoring relationships between individuals involved in AHD efforts. Since its launch in 2015, this mentorship program, which connects individuals seeking guidance in an area of AHD development or operation with those having experience in that area, has offered support to 16 AHD mentees. Currently, additional mentees are waiting for a mentor with experience that matches their needs, and additional mentors for the program are needed. To volunteer as an AHD mentor or to learn more, please contact Kathleen Amos at kamos@phf.org.

More information about the AHD Learning Community and its activities is available through the AHD Learning Community section of the Council website or by contacting Kathleen Amos at kamos@phf.org.

Staged Model of AHD Development

Draft: July 2, 2018



Stage 1: Informal Relationships
- Limited engagement between organizations
- Occasional teaching, internship placements
- Relationship might be on and off

Stage 2: More Established, Longer Term Relationships
- More engagement between organizations
- Recurring internships, teaching, research

Stage 3: Formal Written Agreement
- Formalizing partnership activities
  - What has been occurring
  - What want to occur
- Engagement may be limited to a single area (education, research, or service)

Stage 4: Expansion
- Reaffirming existing elements of the partnership
- Expanding on existing elements of the partnership
- Expanding into other areas (education, research, and service)
- Partnership may be focused on all three areas

Stage 5: Comprehensive Collaboration
- Collaboration on all three areas (education, research, and service)
- Shared personnel and resources

Bonus
- Bringing in additional organizations
- Co-locating facilities

7. Supplemental Materials:

- **Council Constitution and Bylaws**
- **Council Participation Agreement**
- **Council Strategic Directions, 2016-2020**

Council on Linkages Between Academia and Public Health Practice

Constitution and Bylaws

ARTICLE I. – MISSION:

The mission of the Council on Linkages Between Academia and Public Health Practice (Council) is to improve the performance of individuals and organizations within public health by fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities; promoting public health education and training for health professionals throughout their careers; and developing and advancing innovative strategies to build and strengthen public health infrastructure.

ARTICLE II. – BACKGROUND AND PURPOSE:

In order to bridge the perceived gap between the academic and practice communities that was documented in the 1988 Institute of Medicine report, *The Future of Public Health*, the Public Health Faculty/Agency Forum was established in 1990.

After nearly two years of deliberations and a public comment period, the Forum released its final report entitled, *The Public Health Faculty/Agency Forum: Linking Graduate Education and Practice*. The report offers recommendations for: 1) strengthening relationships between public health academicians and public health practitioners in public agencies; 2) improving the teaching, training, and practice of public health; 3) establishing firm practice links between schools of public health and public agencies; and 4) collaborating with others in achieving the nation's Year 2000 health objectives. In addition, the Public Health Faculty/Agency Forum issued a list of "Universal Competencies" to help guide the education and training of public health professionals.

The Council was formed initially to help implement these recommendations and competencies. Over time, the Council's mission and corollary objectives may be amended to best serve the needs of public health's academic and practice communities.

ARTICLE III. – MEMBERSHIP:

A. Member Composition:

The Council is comprised of national public health academic and practice agencies, organizations, and associations that desire to work together to help build academic/practice linkages in public health. Membership on the Council is limited to any agency, organization, or association that:

1. Can demonstrate that agency, organization, or association is national in scope.
2. Is unique and not currently represented by existing Council Member Organizations.
3. Has a mission consistent with the Council's mission and objectives.
4. Is willing to participate as a Preliminary Member Organization on the Council for one year prior to formal membership, at the participating organization's expense.
5. Upon being granted formal membership status, signs the Council's Participation Agreement.

Individuals may not join the Council.

B. Member Organizations:

Council Member Organizations include:

- American Association of Colleges of Nursing (AACN)
- American College of Preventive Medicine (ACPM)
- American Public Health Association (APHA)
- Association for Community Health Improvement (ACHI)
- Association for Prevention Teaching and Research (APTR)
- Association of Accredited Public Health Programs (AAPHP)
- Association of Public Health Laboratories (APHL)
- Association of Schools and Programs of Public Health (ASPPH)
- Association of State and Territorial Health Officials (ASTHO)
- Association of University Programs in Health Administration (AUPHA)
- Centers for Disease Control and Prevention (CDC)
- Community-Campus Partnerships for Health (CCPH)
- Council on Education for Public Health (CEPH)
- Health Resources and Services Administration (HRSA)
- National Association of County and City Health Officials (NACCHO)
- National Association of Local Boards of Health (NALBOH)
- National Environmental Health Association (NEHA)
- National Library of Medicine (NLM)
- National Network of Public Health Institutes (NNPHI)
- National Public Health Leadership Development Network (NLN)
- Quad Council Coalition of Public Health Nursing Organizations (Quad Council)
- Society for Public Health Education (SOPHE)
- Veterans Health Administration (VHA) – Preliminary Member Organization

Membership Categories:

An organization must petition the Council to become a member in accordance with the Council's membership policy. If membership is granted, the agency, organization, or association will become a Preliminary Member Organization for the period of one year. At the conclusion of one year as a Preliminary Member Organization, the Council will vote to approve or decline the agency, organization, or association as a Formal Member Organization. If granted formal membership status, the agency, organization, or association will be reimbursed for travel related expenses for future meetings, if funds permit.

I. Preliminary Member Organization Privileges

1. Preliminary Member Organizations may fully participate in all discussions and activities associated with Council meetings at which they are required to attend.
2. Preliminary Member Organizations retain the right to vote at Council meetings during their preliminary term.
3. Preliminary Member Organizations can participate in any and all Council subcommittee/taskforce discussions that they desire to join.
4. Preliminary Member Organizations' names and/or logos will be included in Council resources that depict Member Organizations during the preliminary term.
5. Preliminary Member Organizations will be responsible for all travel related expenses for attending meetings.

II. Formal Member Organization Privileges

1. In accordance with the Council's travel policy and as funding permits, Organizational Representatives (Representatives) from Formal Member Organizations are entitled to reimbursement up to a predetermined amount for airfare, transportation to and from meeting site, and hotel accommodations for Council meeting travel.
2. As funding permits, Representatives from Formal Member Organizations will be reimbursed at the federally-approved per diem rate for meals consumed during travel to and from Council meetings.
3. Substitutes for officially designated Representatives are not eligible for travel reimbursement.
4. Formal Member Organizations retain full participation privileges in all Council discussions, activities, votes, and subcommittee/taskforces.
5. Formal Member Organizations will be represented either via logo or text in all Council resources that depict membership.
6. Formal Member Organizations must comply with the signed Participation Agreement.
7. Representatives from federal government agencies will not receive funding from the Council for travel or related expenses.

ARTICLE IV. – MEMBER ORGANIZATION RESPONSIBILITIES:

In order for the Council to meet its goals and corollary objectives, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council membership requires that:

- Each Member Organization (Organization) select an appropriate Representative to serve on the Council for, at a minimum, one year. Organizations are strongly encouraged to select Representatives who can serve for terms of two or more years.
- The Representative have access to and communicate regularly with the Organization's leadership about Council activities.
- The Representative be able to present the perspectives of the Organization during Council meetings.
- The Representative attend and actively participate in scheduled meetings and shall not miss two consecutive meetings during a given year unless the absence is communicated to Council staff and approved by the Chair before the scheduled meeting.
- Each Organization identify a key staff contact who will keep abreast of Council activities via interaction with Council staff, attendance at locally-held meetings, and/or regular contact with the Representative.
- During at least one meeting each year, Representatives present the progress their respective Organizations and members have made toward implementing and sustaining productive academic/practice linkages.
- Each Representative (or staff contact) respond to requests for assistance with writing and compiling Council documents and resources.

- Representatives and Organizations disseminate information on linkage activities using media generally available to the Council's constituency and specifically to the respective memberships of the Organizations.
- Upon request of the Council Chair, Representatives officially represent the Council at meetings or presentations widely attended by members of the practice and academic public health communities.
- Upon request of the Council Chair, Representatives assist Council staff with identifying and securing funding for projects, advocating Organizational support for specific initiatives, and serving on Council subcommittees.

If a Representative or Organization does not fulfill the above responsibilities, Council staff will first contact the Representative and Organization in writing. If a Representative fails to address the concerns—for example, in the case of chronic absenteeism at Council meetings—the Council chair may request that a new Representative be selected. Then, if a Member Organization consistently fails to perform its responsibilities after a written warning, Council staff will inform that Organization in writing that the full Council will vote on revoking that Organization's membership. If a majority of all Representatives vote to revoke an Organization's membership, that Organization will no longer be considered a part of the Council.

ARTICLE V. – Discussions, Decisions, and Voting:

A. The following overlying principle shall govern decisions within the Council:

Each Member Organization shall have one vote. Only Representatives or officially designated substitutes can vote. To designate a substitute, Member Organizations must provide the name and contact information for that individual to Council staff in advance of the meeting.

B. Discussions & Decisions:

Council meetings will use a modified form of parliamentary procedure where discussions among the Representatives will be informal to assure that adequate consideration is given to a particular issue being discussed by the Council. However, decisions will be formal, using Robert's Rules of Order (recording the precise matters to be considered, the decisions made, and the responsibilities accepted or assigned).

C. Voting:

1. Each Representative shall have one vote. If a Representative is unable to attend a meeting, the Organization may designate a substitute (or Designee) for the meeting. That Designee will have voting privileges for the meeting.
2. **Quorum** is required for a vote to be taken and shall consist of a majority of the Representatives or Designees of all participating groups composing the Council.
3. **Simple Majority** Vote will be required for internal Council administrative, operational, and membership matters (i.e.: Minutes approvals).
4. The Council will seek **Consensus** (Quaker style – No-one blocking consensus) when developing major new directions for the Council (i.e.: moving forward with studying leadership tier of credentialing). No more than one-quarter of Representatives or their Designees can abstain, or the motion will not pass. Representatives will be expected to confer with the leadership of their

organizations prior to the meeting to ensure that their votes reflect the Organization's views on the topic.

5. A two-thirds **Super Majority** of all Representatives will be required to vote on accepting or amending this Constitution and Bylaws.

ARTICLE VI. – COUNCIL LEADERSHIP:

One Representative will serve as the Council Chair. The Chair is charged with opening and closing meetings, calling all votes, and working with Council staff to set meeting agendas.

The term of the Chair is two years. There is no limit to the number of terms a Representative can serve as Chair. At the end of each two-year term, another Council Representative and/or the current Chair may nominate him/herself or be nominated for the position of Chair. To be elected Chair requires a majority affirmative vote of Council membership. In the event that there are several nominees and no nominee receives a clear majority of the vote, a runoff will be held among the individuals who received the highest number of votes.

To be eligible to serve as Chair, an individual must:

- have served as a Council Representative for at least two years; and
- have some experience working in public health practice.

ARTICLE VII. – MEETINGS:

The Council shall convene at least one in-person meeting a year. Funds permitting, the Council will convene additional meetings either in-person or via conference call. All meetings are open to the public.

ARTICLE VIII. – COUNCIL STAFF ROLES AND RESPONSBILITIES:

The Council is staffed by the Public Health Foundation. Council staff provide administrative support to the Council and its Organizations and Representatives. This includes, but is not limited to:

1. Planning and convening Council meetings;
2. General Council administration such as drafting meeting minutes, yearly deliverables, progress reports, action plans, etc.;
3. Working with Representatives and their Organizations to secure core and special project funding for Council activities and initiatives; and
4. Officially representing the Council at meetings related to education and practice.

ARTICLE IX. – FUNDING:

Council staff, with approval from the Council Chair, may seek core and special project funding on behalf of the Council in accordance with Council-approved objectives, strategies, and deliverables.

Adopted: January 24, 2006
Amended: January 27, 2012

Article I. Mission Updated:	October 7, 2016
Article III.B. Member Organizations Updated:	September 6, 2013; March 31, 2014; August 19, 2015; January 20, 2016; August 18, 2016; May 1, 2017; October 18, 2017; December 20, 2017

The Council on Linkages Between Academia and Public Health Practice

Participation Agreement

The Council on Linkages Between Academia and Public Health Practice (Council) exists to improve the performance of individuals and organizations within public health by fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities; promoting public health education and training for health professionals throughout their careers; and developing and advancing innovative strategies to build and strengthen public health infrastructure. In order to fulfill this mission, membership on the Council requires a certain level of commitment and involvement in Council activities. At a minimum, Council involvement requires that:

- The Member Organization (Organization) selects an appropriate Representative (Representative) to serve on the Council for, at a minimum, one year. Organizations are strongly encouraged to select Representatives who can serve for terms of two or more years.

- The Representative has access to and communicates regularly with the Organization's leadership about Council activities.

- The Representative is able to present the perspectives of the Organization during Council meetings.

- The Representative attends and actively participates in scheduled meetings and does not miss two consecutive meetings during a given year unless the absence is communicated to Council staff and approved by the Chair before the scheduled meeting.

- The Organization identifies a key staff contact who will keep abreast of Council activities via interaction with Council staff, attendance at locally-held meetings, and/or regular contact with the Representative.

- During at least one meeting each year, the Representative presents the progress his/her respective Organization and members have made toward implementing and sustaining productive academic/practice linkages.

- The Representative and Organization contribute to the Council's understanding of how Council initiatives and products are being used by the members/constituents of the Council Organization.

- The Representative (or staff contact) responds to requests for assistance with writing and compiling Council documents and resources.

- The Representative and Organization disseminate information on linkage activities using media generally available to the Council's constituency and specifically to the respective membership of the Council Organization.

- Upon request of the Council Chair, the Representative officially represents the Council at meetings or presentations widely attended by members of the practice and academic public health communities.

- Upon request of the Council Chair, the Representative assists Council staff with identifying and securing funding for projects, advocating Organizational support for specific initiatives, and serving on Council subcommittees.

We have read and understand the Participation Agreement described above and agree to the obligations and conditions for membership on the Council on Linkages Between Academia and Public Health Practice. We understand that membership and representation is voluntary, and we may withdraw Representative and/or Organizational participation at any time if we are unable to meet the above outlined responsibilities.

____ ____________________
Council Representative Designated by Organization Date

____ ____________________
Organizational Executive Director Date

____
Member Organization

Council on Linkages Between Academia and Public Health Practice: Strategic Directions, 2016-2020

Mission

To improve the performance of individuals and organizations within public health by:

- Fostering, coordinating, and monitoring collaboration among the academic, public health practice, and healthcare communities;
- Promoting public health education and training for health professionals throughout their careers; and
- Developing and advancing innovative strategies to build and strengthen public health infrastructure.

Values

- Teamwork and Collaboration
- Focus on the Future
- People and Partners
- Creativity and Innovation
- Results and Creating Value
- Health Equity
- Public Responsibility and Citizenship

Objectives

- Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.
- Enhance public health practice-oriented education and training.
- Support the development of a diverse, highly skilled, and motivated public health workforce with the competence and tools to succeed.
- Promote and strengthen the evidence base for public health practice.

Objectives, Strategies, & Tactics

Objective A. Foster collaborations between academia and practice within the field of public health and between public health and healthcare professionals and organizations.

Strategy 1: Promote development of collaborations between academia and practice within public health.

Tactics:

a. Support the development, maintenance, and expansion of academic health department partnerships through the Academic Health Department Learning Community.
b. Document and highlight progress being made in academic/practice collaboration within public health and the impact of that collaboration.

c. Document contributions of Council on Linkages member organizations, individually and collectively, to improving public health performance through implementation of the Council on Linkages' Strategic Directions.
d. Coordinate with other national initiatives, such as the Foundational Public Health Services, public health department and academic institution accreditation, Healthy People, National Consortium for Public Health Workforce Development, Public Health Workforce Interests and Needs Survey (PH WINS), and Health Impact in Five Years (HI-5) initiative, to improve public health performance through implementation of the Council on Linkages' Strategic Directions.
e. Learn from and share with other countries and global health organizations strategies for strengthening the public health workforce.

Strategy 2: Promote development of collaborations between public health and healthcare professionals and organizations.

Tactics:

a. Identify population health competencies aligned with the Core Competencies for Public Health Professionals that are designed for non-clinical settings.
b. Encourage the inclusion of healthcare professionals and organizations in academic health department partnerships.
c. Document and highlight progress being made in public health/healthcare collaboration and the impact of that collaboration.

Objective B. Enhance public health practice-oriented education and training.

Strategy 1: Develop and support the use of consensus-based competencies relevant to public health practice.

Tactics:

a. Review the Core Competencies for Public Health Professionals every three years for possible revision.
b. Develop and disseminate tools and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into education and training.
c. Work with the Council on Education for Public Health to encourage use of the Core Competencies for Public Health Professionals and academic/practice partnerships by schools and programs of public health.
d. Work with the National Board of Public Health Examiners to encourage use of the Core Competencies for Public Health Professionals in the Certified in Public Health credentialing program.
e. Contribute to the development and measurement of Healthy People objectives related to public health infrastructure.
f. Advance opportunities for using the Core Competencies for Public Health Professionals in the education and training of health professionals and other professionals who impact health.

Strategy 2: Encourage development of quality training for public health professionals.

Tactics:

a. Provide resources and tools for enhancing and measuring the impact of training.
b. Contribute to efforts to develop quality standards for public health training.
c. Explore the desirability and feasibility of creating a process for approving and advancing training for general public health continuing education units.

Strategy 3: Promote public health practice-based learning.

Tactics:

a. Conduct a periodic review of practice-based content in public health education.
b. Develop tools to assist academic health departments in providing high quality practica.

Objective C. Support the development of a diverse, highly skilled, and motivated public health workforce with the competence and tools to succeed.

Strategy 1: Develop a comprehensive plan for ensuring an effective public health workforce.

Tactics:

a. Support the use of evidence in recruitment and retention strategies for the public health workforce.
b. Use existing data to better understand the composition and competencies of the public health workforce.
c. Participate in the Public Health Accreditation Board's workforce development, quality improvement, and performance management activities to encourage use of Core Competencies for Public Health Professionals and academic/practice partnerships by health departments.
d. Explore approaches for determining contributions of credentialing for ensuring a competent public health workforce.
e. Participate in, facilitate, and/or convene efforts to develop a national strategic or action plan for public health workforce development and monitor progress.

Strategy 2: Define training and life-long learning needs of the public health workforce, identify gaps in training, and explore mechanisms to address these gaps.

Tactics:

a. Explore emerging leadership competencies needed within the public health workforce for health systems transformation.
b. Identify skills needed for public health professionals to assume the responsibilities of community chief health strategist.

Strategy 3: Provide access to and assistance with using tools to enhance competence.

Tactics:

a. Develop and disseminate tools and training to assist individuals and organizations with implementing and integrating the Core Competencies for Public Health Professionals into practice.
b. Assist individuals and organizations with using tools and training to implement and integrate the Core Competencies for Public Health Professionals into practice.
c. Encourage use of the Core Competencies for Public Health Professionals as a foundation for the development of discipline-specific and interprofessional competencies.
d. Assist with developing, refining, and implementing discipline-specific and interprofessional competencies aligned with the Core Competencies for Public Health Professionals.
e. Assist other countries and global health organizations with developing and using public health competencies.

Strategy 4: Demonstrate the value of public health to achieving a culture of health.

Tactics:

a. Document contributions of the various professions within public health to achieving healthy communities.
b. Describe the unique contributions that public health professionals can bring to health systems transformation.
c. Encourage public health professionals to engage other professions and sectors in developing strategies for achieving healthy communities.
d. Document how public health research can and does contribute to achieving healthy communities.
e. Participate in, facilitate, and/or conduct a profile study of the public health workforce.

Objective D. Promote and strengthen the evidence base for public health practice.

Strategy 1: Support efforts to further public health practice research, including public health systems and services research (PHSSR).

Tactics:

a. Identify gaps in data and opportunities for improving data for conducting research relevant to practice.
b. Identify emerging needs for public health practice research to support health systems transformation.
c. Collaborate with other national efforts to help build capacity for and promote public health practice research.
d. Convene potential funders to increase financial support for public health practice research.
e. Assess progress related to public health practice research.

Strategy 2: Support the translation of research into public health practice.

Tactics:

a. Identify ways to disseminate and improve access to evidence-based practices.
b. Demonstrate the value of public health practice research to the practice of public health.
c. Explore opportunities to support The Guide to Community Preventive Services.

Strategy 3: Encourage the engagement of public health practitioners in contributing to the public health evidence base.

Tactics:

a. Develop and support implementation of an academic health department research agenda.
b. Foster the development, sharing, and use of practice-based evidence.