Performance Management Collaborative
Learning Project Report #7

Competency-based Training, Credentialing and Accreditation: Tools of Performance Management? —Barney Turnock
And
Credentialing: A National Perspective —Lee Thielen

Denver, Colorado
October 12, 2001

Materials for the Meeting

Readings for this session were the July 1998 issue of the *Journal of Public Health Management and Practice (JPHMP),* an issue entirely devoted to the accreditation of local public health agencies. In addition, the Collaborative was asked to read two *JPHMP* articles from the July, 2001 issue, "Competency-Based Credentialing of Public Health Administrators in Illinois" by Turnock and "Partnership for Front-Line Success: A Call for a National Action Agenda on Workforce Development" by Lichtveld, et.al. A handout at the meeting was the Council on Linkages "Core Competencies for Public Health Professionals" published in April 2001. Dr. Turnock made his presentation slides available to the Collaborative.

Accreditation and Credentialing: Barney Turnock

Substantial attention has been focused on public health workers recently, including the development of leadership institutes, management training and institutes, development of public health competencies, Centers for Public Health Preparedness and the Public Health Training Networks. The strategic elements that have evolved in these initiatives to improve public health workforce development are:

- ✓ Monitor workforce composition
- ✓ Identify competencies/develop curricula
- ✓ Design integrated learning system
- ✓ Assure financial support
- ✓ Conduct evaluation and research
- ✓ Use incentives to assure competency

Kristine Gebbie (2000) examined public health worker density, collecting data showing public health workers per 100,000 population. 16 states had 140 –566 public health workers for every 100,000 people, 17 states had 77 to 140 public health workers for every 100,000 people, and 17 had 37-77 public health workers for every 100,000 people.

Public Health Workforce: US and Selected States, 2000 US Employment Census data showed that the ratio of local government and state government employees varies significantly among states.

When combined, both studies underscore the notion that we do not have a clear understanding of the types of professionals who are delivering public health services. Because the definition of a public health worker varies so greatly we cannot prove we have fewer public health workers today than before.

Local public health workforce ratio by size of jurisdiction was studied in Illinois in 1999 by Turnock, showing higher ratios of FTE's per population in rural counties but core functions were a more frequent part of public health work in the more populated counties. So just having more workers may not help us. We need to be concerned with individual competency, but also with the links between workforce characteristics and the performance of public health core functions and essential public health services (EPHS).

Barney's lessons learned:

- The state/local governmental public health workforce is small (~400,00) but may not be shrinking.
- The governmental public health workforce ratio varies considerably across the US.
- Within each of the 50 states, the public health workforce is unevenly distributed.
- The state/local public health workforce is diverse in terms of functions, disciplines, credentials, and job titles.
- About half of the local public health workforce is professional; nurses are the largest professional group (environmental health the largest overall).
- Agency heads have diverse education backgrounds and varying experience.
- The presence and density of selected professional positions have a positive influence on core function and EPHS performance.
- In some states (but not all) the least populated areas have the highest workforce to population ratios, suggesting that consolidation may improve efficiency.
- Local health department (LHD) characteristics influence the number and types of public health workers, (e.g. home health agency status for rural LHDs, extensive clinical service delivery networks for urban LHDs).
- Local health jurisdictions with larger budgets and staffs tended to have higher core function-related practice performance scores.
- The effects of workforce quantity and quality on core function performance appear to be mediated by characteristics of the agencies in which they work (suggesting links with organizational and local public health system performance standards).

Barney showed CDC's "The structure of a work-doing system" (based on Fine and Cronshaw, 1999) and the Public Health Training Pyramid – using preparedness model to look at types of workers needed. Bottom base is basic orientation and acculturation to public health for all public health workers (Public Health 101: What Public Health Is, How It Works, and Why It Is Important). The middle rung addresses the needs of Public Health Managers, Community Health Improvement Specialists, PH Nurses, Environmental Health Professionals. These professional workers need cross-cutting

competencies for public health core functions/EPHS via certificate training programs for key groups. The top of the pyramid is the specialized training in such areas as bioterrorism, emerging infections, and other public health needs and priorities, targeted at specific groups of professionals.

The middle group has been a recent focus for continuing education, training and credentialing requirements. One example of a recent effort to credential public health professionals is the newly-created Illinois board to develop a process and criteria to credential public health administrators. It is called a Public Health Administration Certificate. Started in 1998, only a few professionals have been certified so far with a Public Health Administration Certificate.

Credentialing Issues

Who will credential (what organization)?
At what education level?
Nature of credential (government, private, mandatory)
Role definition (definition of practice field)
Determination of competencies
Years of experience
Benefits to society
Benefits to practitioners
Grandfathering

Some C's of credentialing

Concerns

Controversy

Lots of fears about the credentialing system limiting people's ability to get jobs or move up the ladder. Many concerns are disappearing as time goes on. It's not so controversial now and instead people are upset about the complexity of the process.

Credibility

State expectation of certificate – asked for in certain jobs

Consistency

Application review has brought up many issues. For example training/course documentation. Discussions about tests. Many feel that won't be adequate. Must include recognition of work accomplished – demonstration of competency to work in public health though not in a traditional public health agency

Competency based

Moving toward training programs targeting the competencies used in certification

CEUs

Today done on discipline specific issues rather than global public health issues. Some process on a national level to approve CEU options so they are evaluated in a consistent fashion

Compatibility (with existing credentialing programs)
Mid-level credentialing for other disciplines may be needed because discipline specific competencies are too difficult. Lots of middle room. State, federal?

PH Credentialing Framework

	Academic preparation	**Work experience**	**Basic Competencies (acquired or demonstrated)**	**Crosscutting Competencies (acquired or demonstrated)**	**Special Competencies (acquired or demonstrated)**
Front Line PH Worker	NA	NA	Public Health Practice (PHP)	NA	NA
Senior Professional	College	3 yrs	PHP	PHP, Community Health Assessment (CHA), Advocacy and Policy Development (A&PD), Program Dev./Evaluation (PD/E)	
PH Manager/ Administrator	College degree	3 yrs	PHP	PHP, CHA, A&PD, PD/E	Public Health Adm.(PHA)
Bioterrorism Specialist	?	?	PHP	?	Bioterrorism
Leader	?	5 yrs	PHP	PHP, CHA, A&PD, PD/E	Leadership Developmt.

A National Perspective: Lee Thielen

CDC has convened four committees on workforce development. One of these committees is on Incentives and deals with credentialing and certification of the public health workforce. A broad-based group is studying the issue and developing strategies for improving the public health workforce.

Members include: APHA, ASPH, NACCHO, ASTHO, NEHA, state and local representatives.

Why this effort? Most public health leaders lack formal training in public health. There is increasing awareness of the need to recognize competency in public health practice, ensure standards are met, and build systems that produce more competent leaders. In addition, a better knowledge of the workforce will enable better planning for future needs.

Decisions made about credentialing:

1. has to enhance existing programs
2. needs significant lead time in development
3. should incorporate incentives
4. should enhance effectiveness of public health work and workers
5. should provide data
6. be inclusive – look at whole workforce
7. be practitioner led
8. link to infrastructure
9. should have local value
10. should be realistic and affordable

The basic outlines of a strategy that is evolving follow.

Tier one – basic/essential PH worker level

- inventory existing orientation or essential training programs and the public health curricula being used.
- utilize the training centers currently being funded by HRSA and CDC and use academic programs and schools as a beginning step to develop and offer training.
- examine possible delivery mechanisms for essential training including distance-based and locally delivered training. (NACHHO working on this)

Tier two – other accredited professionals

- convene a group of existing credential agencies or organizations that have the potential to add public health competencies.
- work with professional groups that aren't credentialing organizations such as the public health informatics professionals.
- begin discussions with personnel management leaders or directors to add public health competencies and recognition to the positions of public health workers.
- identify the competencies for Tier One, Two, and Three.

Tier three – leader/manager

- outline various models for credentialing including balancing experience, educational preparation, and competency testing.
- examine options of assessing competencies through such organizations as the Council on Education in Public Health and the Association of Teachers of Preventive Medicine.
- encourage the ongoing steering committee of the Association of Schools of Public Health and the American Public Health Association to include representation of public health academic programs outside of schools of public health.
- review with the competencies and curriculum committee the competencies of public health leaders.