

CORE COMPETENCIES DEVELOPMENT

By: Brent Moloughney

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Welcome. My name is Brent Moloughney, and this is an audio web presentation describing the development of a draft set of public health workforce core competencies.

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This presentation will describe what competencies are, why they are relevant to workforce development, some of the initiatives occurring elsewhere in the world that inform this work, the actual process of developing the competencies, and how they might be used.

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Well the term *competencies* may be new to some. Really the idea is not because really competencies are just the *package* of knowledge, skills, and abilities that are required either for an organization or for individual members in order for effective and efficient functioning.

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Competencies are a basic building block when thinking about strengthening the workforce. As shown in this slide competencies can help you identify what the skills and abilities are required for an organization, inform the development of curriculum, assist in the development of assessing training needs that can then form continuing education programs. Also be used as a common vocabulary for consistency in the development of job descriptions and performance assessment, and overall provide a description of the knowledge, skills, and abilities required for public health practice.

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This slide depicts a simplistic version of the iterative process by which practitioners initially develop competencies and then can have their competencies increased over time through a process of assessment, identifying gaps and priorities in training, developing and implementing training, and then having support to incorporate those new skills into practice. And of course, there would be a whole range of incentives and supports and *tools* that ideally would be in place to allow this to happen and many of these would be competency-based. So for example, one could imagine a *tool* that would be competency-based to help assess training needs in a particular position or program.

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Now the idea to identify competencies for public health in Canada came from a number of different directions. First of all, a report that was done by Nevis Consulting looking at best practices in public health workforce development in other countries, of its three key recommendations one was to strongly recommend the development of public health core competencies. In a series of regional consultations held across Canada in early 2004, a reoccurring *theme* from those was the encouragement to identify the competencies required for public health practice.

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The world of competencies has been rapidly enlarging in recent years. Unfortunately, the terminology that is being used is not being used in a common fashion. Here are a few tips. Core competencies are often used to describe the set of competencies shared by all public health practitioners. In other words, what are the competencies required of public health practitioners regardless of their disciplinary background? Now if there are core competencies, which are the common ones, then of course there will be non-core ones and for these the term *technical* is being used in that they are not common to all practitioners. There's also the term *discipline-specific*. This is typically used to describe the set of core and technical competencies, that is, a package to define a particular discipline.

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Discipline-specific is sometimes also used to describe particular individual competencies that are unique to a particular discipline. Frankly, I don't find that terribly helpful and I think that the more one looks at competencies of different disciplines, fewer and fewer competencies are actually unique to any particular discipline. It's the *package* of competencies that define a discipline. To add further confusion, sometimes when talking about disciplines those groups will talk about the core competencies *within* their discipline in contrast to more specialized competencies that certain *members* of their discipline will have. As I said, it's a little bit complicated and you have to listen carefully sometimes as people talk about competencies to know exactly what it is that they are talking about.

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This diagram attempts to show on very simplistic level the universe of possible competencies required for public health practice. They are the set of core competencies common to all practitioners and then beyond those there are many, many, many additional technical competencies that only particular individuals or particular disciplines will possess.

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I've now added a hypothetical discipline which by definition should have all the core competencies as well as now a set of additional technical competencies, and the package of those technical and core competencies would be their discipline-specific competency set.

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Two additional disciplines have now been added and as you can see they all intersect around the core competencies, which are common to all disciplines, and then they have additional technical competencies for each of their discipline sets. You will notice that, in this hypothetical example, that there's overlap in some of the technical competencies between disciplines. When you think about it that makes sense. For example, the competency to provide an injection is possessed by at least two or three different disciplines in public health. Certain analysis could be possessed by a variety of disciplines.

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This slide summarizes some of the work that's been occurring in developing public health competency sets in different countries. In the US, they've had two core competency sets identified. A variety of program- and discipline-specific competency sets as well. In the UK, they have a very detailed set of occupational standards which are composed of sections on competencies. They've also identified competencies for public health specialist positions. Australia has been mainly discipline-specific competency sets, namely those for NPH graduates as well as those related to public health officer training.

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The preliminary work on competencies here in Canada focus on core competencies or the set of cross-cutting skills, knowledge, and abilities necessary for the broad practice of public health. Related to our previous slide on core competencies these are to transcend the boundaries of individual disciplines, should reflect the common knowledge, skills, and abilities of practitioners, and therefore would be independent of any particular program or topic. Admittedly, they could also be further characterized with respect to depth of understanding or proficiency level as well as to what extent of that depth or proficiency should be related to a role in the organization, for example, frontline, supervisory, management, specialist positions. It has also been described, although I'm less unsure of it myself, the advantages of doing this, of comparing generic competencies versus those that are specific to public health alone.

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In developing the draft set of core competencies there were a couple of principles underlying the work I was doing. First off that it was a *drafting* of a set. You know once the set was put together initially there was going to be a need for the field and stakeholders to have an opportunity to take a look at them – consider, digest, discuss, and make whatever changes were needed. Secondly, the request put to me was that the competencies needed to be based on the core system functions of public health and so these are the big five: the query functions of assessment and surveillance, and the intervention functions of prevention, promotion, and protection.

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This slide provides a very high level overview of the process of developing the core competencies. As previously stated, the starting point were the core functions although there was a need to break these down into more detailed bits or components and these are referred to as core elements. Existing competency sets from other countries were brought into play and then decisions were made for which items to include. The next slides will provide this description in more detail.

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A brief word about the core functions. So the big five functions that I described are, of course, derived from the Advisory Committee on Population Health from a previous report on public health capacity that they made in approximately 2001. In some of my early consultations, some individuals suggested that there's a need to also talk about advocacy or emergency preparedness as system functions. Certainly, one could have that discussion, but from a competency development perspective as long as the concepts of advocacy and emergency preparedness are considered at some point along the way, you don't really need to have the discussion about whether these items are additional functions or are contained within the big five. Whether they're separate or not is really an issue of emphasis, not content.

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Once I began to work with the core functions, it became clear that they were at too high a level and I needed to break them down into constituent parts and refer to these as the core elements. Now one of the challenges here is that while we seem to know what these functions are it's a little tougher to actually tease them out. It also became clear that the functions are not mutually exclusive; there are grey zones between them. I mean just think of health promotion and preventing chronic diseases. Very quickly, you get into a fuzzy zone as to what the boundaries are between those two functions. I made an initial attempt at breaking these down and had the fortune of bouncing it off a group of people at the 2004 CPHA conference and received some useful

feedback. As I began to work with the functions on the constituent elements it became clear that they were going to be useful as a way to assess the content of the existing competency sets from other countries.

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Early on it became clear that there were essentially two big options in terms of developing the set of competency statements. First off, we could attempt to identify competency statements from scratch. The other option was to take a look at existing sets of core competencies and take advantage of the many hours of work and the thousands of people who had commented on them and utilize these at least as a starting point to compare and map them to the core elements that had been identified related to the core functions.

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There were four main core competency sets identified. Two from the US which in fact had shared a common origin until there was a break off group; and then two from the UK, one very detailed, one relatively simple; and then two from Australia which turned out to be discipline-specific and then were given no further consideration. In looking at the four from the US and the UK, it wasn't obvious that any were the answer. I mean part of me was tempted to just grab one of those and say this is the answer, but frankly while they were all good in their own way it looked as though there was going to be a need to go through each of their competency statements and see how they would map out to the core elements. It was also clear that it would be preferable to work with these existing competency statements as a first step versus attempting to start from scratch and design all the competencies themselves.

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In the process of mapping those many hundred existing competency statements from other countries to the core elements, a couple of things became clearer. First, that in those existing competency sets many had greater emphasis on certain areas of public health than others. The other thing was that there were many competencies which were in fact not unique to any particular function but were cross-cutting, they applied to multiple functions. For example, items like policy development and program planning obviously those don't just exist for one function but are required for multiple ones.

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While working with these many hundreds of competency statements it became clear very quickly that there was a need to reduce their number to a workable set. And so comparisons were made within core elements, within functions and across functions to eliminate duplication of concepts between statements, attempt to keep the statements simple but at the same time still useful.

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While that pruning activity got the number of competencies down to under 90 initially, there were still too many items to work with or attempt to describe and so similar to what's been done in other competency sets the items were grouped together by common theme or domain.

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This diagram shows that in terms of taking that big pool of competencies and beginning to separate them out into individual domains so that like is with like.

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Now I could easily make up a story and say I used some big fancy computer program that did cluster analysis and created all these domains, but that in reality wouldn't be truthful. Instead you can see this highly sophisticated dining room table being used to try to cluster all of those individual competency statements which are in sort of a lightish green colour in the middle and then try and see how they match up with two approaches, two domains, which are in the pink across the top and then sort of the bluish colour down the near side, which I had taken from two existing competency sets, and basically moving items around to see what would hold together the best and be the easiest to try and describe things.

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The two main sets of domains that I was working with came from the US, namely from the Council on Linkages Between Academia and Public Health Practice, which is probably the best known core competency set and is readily available on the Net, and the other referred to is the Competency Handbook which was led in development by Emory University in Atlanta. And in fact most of the items that appear in the Canadian draft set of public health competencies can be derived directly or indirectly from those two US groups. The UK Skills for Health domains, it ended up being a mix of functions and other concepts and I found those less useful. I also made a decision that for a core competency set reflecting the competencies required of all practitioners that really didn't think that there needed to be separate domains for items such as information management and financial planning or management.

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As a final step, I did some double-checking. Some of the literature on competencies described that each should have a clear verb, content and context, and so reviewed the competency statements and made a few small changes. Because many of the statements had been derived from the Council on Linkages competency set, I had some concerns that there were items that did not make it through the process and so I went back and checked all of the items that had been deleted to make sure that those decisions still seemed reasonable.

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So this diagram provides an overall summary of this process. So it started out with those five core functions of public health that are shown across the top of the slide. These were then broken down into the constituent core elements, and these were used to help make decisions about what competency statements should be in a set of core competencies. Then individual statements were grouped together based on common themes with some guidance on how domains had been structured in other competency sets. And so that left us with the seven competency domains that are shown there: core public health sciences, analysis and assessment, policy development and program planning, partnership and collaboration, social-cultural competencies, communication, as well as leadership and system approaches.

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So at the final stage, we ended up with 62 individual competency statements grouped into seven domains and their origins shown as such – either having been directly taken over or with modification. Most of them as I'd said had come from the US Council on Linkages, in fact 42 of the 62, some additional items from the Competency Handbook, seven from the UK Skills for Health, and four with clearly blended origins, and one entirely new statement.

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As I said as one of the principles in the development of these competency statements that this is a draft set. There needed to be something to show to people, to ask for their feedback and that is in fact what has been done. So it's critically important to have some form of consultation process to get feedback on this initial set. The other thing is to recognize is that competency sets will evolve over time and that's not only due to experience working with them and tweaking them appropriately, but also that practice for public health will change and so there will be a need to emphasize certain aspects more than others in the future and presumably that can be done through the competencies.

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Creating competency sets is not an end in itself. There still needs to be ongoing leadership to support their use. In fact, one of the difficulties that has been experienced in other countries is that those supports were not available and therefore the competencies were not used as much as people had hoped. And so the types of things that go through my mind are tools, so for example, tool sets that take the competencies and package them the way that people can use them to assess training needs, to utilize the core set, to inform the development of discipline-specific sets. And in fact, a number of disciplines have been using the core competencies to inform their work, and examples would be the public health nurses, public health inspectors, public health epidemiologists, as well as

health promoters. Another area for future work as well is the use of the competencies to inform the development of core and continuing education in public health. So overall a key point here is that the competencies are not an end in themselves but rather a tool or a basic building block to assist development of the public health workforce.

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Well this ends the formal presentation on the development of the public health workforce core competencies. Thank you for your interest in this topic and hopefully the foregoing information has been helpful to you. Thank you.