

As of June 26, 2009

**DRAFT MINUTES**  
**Leadership Group Meeting**  
**ASPH Preparedness and Response Core Competency Development Project**  
Hotel Monaco, Alexandria, VA  
June 2-3, 2009

**Members Present:**

Audrey Gotsch, Co-Chair (UMDNJ)  
Bill Keck, Co-Chair (NEOUCOM)  
Tanis Batsel (Office of US Navy Surgeon General)  
Rick Clover (Louisville)  
Kristine Gebbie (CUNY)  
Jim James (AMA)  
Mike Handrigan (ASPR)  
Jack Hermann (NACCHO)  
Kraig Humbaugh (Kentucky DOH)  
David Marcozzi (DHHS)  
Kathy Miner (Emory)  
Bill Riley (Minnesota)  
Steve Rottman (UCLA)  
Ken Schor (USUHS)  
Andrea Young (CDC)  
*Liaison* Craig Thomas (CDC)

**CDC:**

Daniel Sosin

Wanda King  
Robyn Lebovitz

**Consultant:**

Judith Calhoun (Michigan)

**ASPH:**

Harrison Spencer  
Dorothy Biberman  
Laura Biesiadecki  
Katie Fischer  
John McElligott  
Elizabeth Weist

**Leadership Group Members Not Able to Attend Meeting:**

D.W. Chen (Dept. Defense)  
Kimberly Elenberg (DHHS)  
Vanessa Murphy (Rensselaer County, NY)  
Peggy Wittie (Collin County, TX)

**Welcome and Opening Remarks**

Dean Gotsch and Dr. Bill Keck welcomed everyone to the meeting. Dr. Keck introduced ASPH President & CEO Harrison Spencer, who thanked everyone for attending the meeting and thanked the CDC for its years of support for academic public health. Dr. Spencer also expressed thanks to the CDC Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) for its support of development of public health preparedness and response competencies in line with the congressional mandate from the 2006 Pandemic and All-Hazards Preparedness Act (PAHPA).

After introductions by the attendees, Dr. Keck reviewed the agenda for the meeting and the charge to the Leadership Group, which is to provide guidance for the development of public health preparedness and response core competencies for the public health workforce. Dr. Keck highlighted the objectives of the meeting, which included:

- Review: 1) PAHPA legislation and, 2) Preparedness and Response Competency Model development process charge and roles;

- Identify: 1) Model development process tenets and guidelines, 2) Level of integration with existing frameworks/models, 3) Target audience, and 4) Level of performance (if applicable); and
- Specify: 1) Model framework, 2) Performance domains, and 3) Core competencies.

Dean Gotsch reviewed Section 304 of the Pandemic and All-Hazards Preparedness Act (PAHPA). Parts d(3), d(4), and d(5) of Section 304 relate to the development of competency-based curricula, competency-based training programs, and content of the core curricula and training programs.

Also, Dean Gotsch reviewed the roles of all participants in the project (e.g. Leadership Group, Workgroups, consultant, and staff). The Leadership Group will:

- Guide development of performance domains and core competencies,
- Assist in developing strategies to reach the target audience for inclusion in development, review, and dissemination of a model,
- Promote the project with constituent groups, and
- Consider ideas and concerns of their own constituent groups and key partners about the project.

Dean Gotsch reviewed the project timeline\*. Workgroups will be formed in June-August, begin their work in September, and finish in January 2010. A Model Integration Meeting will occur in March 2010 and the draft competency model will be submitted to the CDC COTPER Board of Scientific Counselors for external review in April 2010. The finished competencies will be released to the public by July 2010.

Finally, Dean Gotsch shared some preliminary planning tenets and guidelines. She said the competency model will:

- Build on existing work in the emergency preparedness and response field,
- Reflect an all-hazards approach,
- Target the public health workforce,
- Provide a proposed national standard of knowledge, skills, and abilities for public health response to emergencies,
- Guide core curricula development and enhancement for the public health workforce, and
- Meet education and training requirements specified in the 2006 Pandemic and All-Hazards Preparedness Act (PAHPA).

### **Public Health Emergency Preparedness and Response Framework**

Dr. Daniel Sosin reviewed a PPT (see

<http://www.asph.org/userfiles/PrepResponseLeadershipMeeting2009June-DanielSosin.pdf>) on how the public health and medical emergency response systems

work together, stating that medical care deals with individual needs whereas the public health system is population-based, then presented a framework for the interaction of the two systems. Dr. Sosin said the medical emergency response system supplements

medical care providers, supports on-site care, and optimizes patient distribution while the public health emergency response system informs medical response, reduces medical surge, and informs emergency response decision making. He then framed the current competency initiative squarely within public health preparedness and response and, in closing, stated that we are focusing on the unique functions provided by public health while integrating the complementary roles in an all-hazards response in this competency effort.

### **Overview of Competency Development Process**

Consultant Dr. Judith Calhoun discussed the many resources available to the Leadership Group and those that will be developed for future workgroups. All materials will be online at [www.asph.org/competency](http://www.asph.org/competency) under the Preparedness and Response Core Competency Development Project.

Dr. Calhoun highlighted key parts of the Resource Guide, which will serve as the main point of reference for the Leadership Group members. She pointed out the Department of Homeland Security's Target Capabilities List and reviewed the anatomy of a competency model. To ensure participants speak the same language, Dr. Calhoun included a glossary of terms in the Resource Guide. Since the competency model will be built using Bloom's Taxonomy of Educational Outcomes, Dr. Calhoun reviewed the key elements of Bloom's Taxonomy and encouraged Leadership Group members to become more familiar with it.

Dr. Calhoun echoed the preliminary tenet mentioned by Dean Gotsch, that the competency model will be built on existing work in the emergency preparedness and response field. As such, the Resource Guide includes several examples of relevant competency models in use (e.g. Bioterrorism & Emergency Readiness: Competencies for All Public Health Workers and Council on Linkages). Several of the individuals who helped develop the relevant models are members of the Leadership Group. Dr. Calhoun presented a comparison of the existing relevant competency models.

Dr. Calhoun then asked the attendees to identify project organizing tenets and guidelines. Proposed guidelines, not prioritized into any order, included:

1. Build on existing work in the emergency preparedness and response field,
2. Target the public health "professional" (minimum baccalaureate education – representing 75% of the preparedness and response workforce) – building upon discipline-specific skill sets, however, there was concern that this approach would not be sufficient,
3. Provide a proposed national standard of knowledge, skills, and abilities for public health preparedness and response to emergencies,
4. Guide core curricula development for the improvement and sustainability of the public health workforce,
5. Meet education and training requirements specified in the 2006 Pandemic and All-Hazards Preparedness Act (PAHPA),
6. Reflect an all-hazards approach,

7. Tie into: the DHS Target Capabilities List, the FEMA resource typing, and the disaster management cycle,
8. Consider common and cross-cutting core competencies across public health and clinical care (and unique competencies associated with these),
9. Use three performance levels,
10. Reflect a population health approach to disaster response,
11. Consider that competencies don't exist independent from the system in which the person operates,
12. Use an interdisciplinary approach,
13. Consider the model as representing core foundational, minimum national standards (not a ceiling or cap),
14. Consider the need for enhanced competencies for people in leadership positions -  
- leadership may need to cross-cut all the domains and not stand-alone,
15. Enable people to perform better in a multi-disciplinary group (this set could supplement other sets) and while we cannot train teams for effective team behavior, we can train individuals, and
16. Understand the public health system is bigger than public health departments.

**Breakout Groups**

Attendees were divided into three breakout groups, as follows:

Group A	Group B	Group C
Tanis Batsel Rick Clover Kristine Gebbie Mike Handrigan Steve Rottman Craig Thomas	Kraig Humbaugh Jim James Wanda King David Marcozzi Kathy Miner	Jack Hermann Bill Riley Ken Schor Andrea Young

The breakout groups were charged to:

1. Identify the target audience
2. Consider inclusion of prior work
3. Discuss integration with other models
4. Discuss performance levels

Staff tracked notes and flipcharts from each breakout in attachments A, B, and C. See Day 1.

Attendees from all breakout groups joined together to report out their findings. There was agreement the target audience would focus on the public health preparedness and response workforce.

Prior work attendees suggested referencing when creating this model includes:

- Council on Linkages (latest, pending version)
- CDC Bioterrorism and Emergency Readiness
- Disaster Medicine and Public Health Preparedness
- National Incident Management System (NIMS)

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- ESF-8
- AHRQ Interdisciplinary Team Curriculum
- IOM content areas

Below is a summary of the proposed possible approaches for developing the preparedness and response competency model:

- Nine audiences in the CDC BT model staff categories
  - Include mental health
  - Change PH information staff to include Communications and Education staff
- Three sector approach -- #1
  - Government (federal, state, local, tribal)
  - Private
  - Volunteer
- Three sector approach -- #2
  - Field responders
  - Emergency Operations Center (EOC) staff
  - Leaders and liaisons
- Leadership roles
- NACCHO public health functions (8-10 important ones)
  - Admin
  - Surveillance
  - Communicable disease control
  - MCH
  - Environment
  - Chronic
  - Lab services
  - Mental health
  - Home health

Below is a list of the recommendations for levels of performance:

- Need a broad framework, but specific roles
- Must tie into Bloom's taxonomy, application level or above
- Three levels are sufficient (novice, proficient, and expert), e.g. beginner, mid-level, senior
- Basic, intermediate, and advanced (with leadership woven into all this)
- Label of proficiency could be specific to the response
- Expert, proficient, novice

On June 3, the breakout groups resumed and were charged with identifying:

- Model framework,
- Performance domains,
- Four to six core preparedness and response competencies per domain
- Recommendations for workgroup planning and development activities
- Resources for model development

Staff tracked notes and flipcharts from each breakout in attachments A, B, and C. See Day 2.

### **Model Framework**

It was agreed the competency model would be framed in terms of public health and that it should align with the Department of Homeland Security's Target Capabilities List (i.e. the four mission areas of Prevent, Protect, Response, and Recover). A three-faced cube with the competency domains, levels of performance, and TCL mission areas was proposed.

### **Performance Domains**

Preliminary domains, which need more refinement before workgroups can be formed, included (individuals suggested or who volunteered to lead in defining the domains, if the domain is retained in the final model, are noted in brackets):

- Planning (training, exercising, and restoring) [ Steve Rottman ]
- Surveillance (data assessment analysis, detection, and monitoring) [ Ken Schor ]
- Communication [Kathy Miner]
- Risk management (hazard analysis and mitigation and safety, security, and risk management) [Kraig Humbaugh]
- Evaluation (and improvement) [ Craig Thomas]
- Law and ethics [ Jim James]
- Community preparedness (coalition building, cultural competency) [ Wanda King]
- Incident management (inter-agency coordination) [ Andrea Young]
- Resource management (economics of disaster) [ Mike Handrigan]
- Teambuilding [ Bill Riley]
- Leadership [ Kristine Gebbie]

### **Discussion**

- Suggestion to not remove the word “public” from anything since the first people on a scene are usually untrained bystanders, then EMS, then hospitals. The continuum of a disaster is long,
- To train people associated with health departments to be competent and to provide a sustained response is our goal here,
- Specific competencies needed by disciplines are being defined by others, while the public health role is not specified. We need to clarify the PH definition,
- There are common, cross-cutting competencies across the system,
- Training does not guarantee a high level of performance. How to focus on the individual to allow him/her to perform better in a multi-disc group?,
- While both “Prepare” and “Protect” fall under the “Prevention” umbrella, the former is more disaster-specific and the latter is more relevant to public safety, inclusive of law enforcement.

### **Closing**

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Dr. Keck and Dean Gotsch thanked participants for attending the meeting and for committing to the competency development effort. They then adjourned the meeting at 3:00 p.m.

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*\* Post-meeting, CDC and ASPH made a decision to hold the next Leadership Group meeting on Monday, August 31 in Atlanta, GA.*

## **Attachment A: Breakout Group A**

### **Day 1**

#### **General Points:**

- Leaders in PH can come from any discipline
- 75% of the people in PH have bachelor's degrees. At the state and local level, a huge percentage are nurses. The average size of a health department is 19, according to a NACCHO study.
- In the FEMA/NIMS framework, resource typing = capability.
- PH operations fold into an ICS framework.
- DHHS serves to coordinate federal assistance to support state, local, and tribal entities during a response (with special attention to the medical needs of responders and at-risk people).

#### **The flipcharts include the following information:**

##### **Tenets and Guidelines**

- Use an interdisciplinary approach
- Consider that many health departments are small (n=19)
- Consider that functions are more important than specific training
- Target the public health professional (with at least a bachelors)
- Demonstrate that preparedness and emergency response is public health
- Set a baseline/minimal standard
- Realize that competencies are demonstrated by individuals, but are influenced by the capacity of the organization in which the person works
- Plan for the competencies to be developed in the context of the their contribution to a robust public health system
- Consider that the TCLs can help inform the development of the competencies
- Plan for enhanced competencies for people in leadership and decision making positions
- Incorporate elements of leadership into each domain (no silos for leadership)
- Indicate how and when to “ring the bell” in an emergency (focus on the leadership to sort the appropriate action/response)
- Assure that all personnel are trained to appropriate NIMS levels and the roles they are likely to fulfill in an emergency

##### **Prior Efforts/Frameworks/Models to Reference**

- CDC Bioterrorism competencies (cross-checked w/the Council on Linkages competencies)
- Disaster medicine competencies (cross-checked w/the Council on Linkages competencies)

##### **Target Audience**

- The “floor” should be the baccalaureate degree

- A major group includes people in leadership jobs
  - Heads of a major group or department
  - Agency/organization heads
- Other groups should be grouped by public health function, e.g. epidemiologist, MCH, and can be characterized by the most recent NACCHO report on health departments from 2005

### **Model/Framework**

- The group then reviewed the five phases of a disaster management cycle with the eight public health domains and determined the phases (preparedness, response, mitigation, recovery, and evaluation) loop around again and are cross-cutting while the domains {Liz checking with Kristine G.}...
- Members discussed the NACCHO public health functions/operations as helpful framework, as follows:
  - Administrative
  - Surveillance (infectious and chronic disease)
  - Communicable disease control (plus immunizations)
  - MCH
  - Environment (food and vector control)
  - Chronic disease (screening, education, prevention)
  - Lab services
  - Mental health
  - Home health
- Levels of performance include the following\*:
  - Expert (adapt, apply, and can perform under extreme circumstances)
  - Proficient (does not need to consult the “how to” book)
  - Novice (must consult the “how to” book)

\* Note that it is possible to be a novice in one area, while expert or proficient in another area.

### **Day 2**

Group members noted that in the U.S., most emergencies are natural disasters. They then agreed that both medicine and public need to have the core, common capabilities of Prevent, Prepare, Respond, and Recover and put forward eight cross-cutting competencies, as follows:

1. Mitigation (prevention)
2. Planning
3. Communications
4. Community preparedness (e.g. emergency health education)
5. Risk management

6. Intelligence and information sharing
7. Public health law
8. Evaluation

They added that this project provides a great opportunity to set the core for PH and medicine.

Under **Prevent (P1)**, the members loaded the following possible competencies:

- Identify data/research
- Monitor and detect/surveillance
- Assess
- Analyze hazards/vulnerabilities, assess populations/demographics, perform risk assessments, determine risk resource ratios
- Manage resources
- Eliminate risk

Under **Prepare (P2)**, the members loaded the following possible competencies:

- Develop an inter-agency and multi-sectoral all-hazards plan
  - Continuity of operations
  - Community coalition building and public-private partnerships
- Train to the plan (and work effectively in teams)
- Exercise/drill at all levels
- Prioritize risk
- Scale the response plan
- Identify resource response thresholds
- Advocate for policy, research, and development

Under **Response (R1)**, the members loaded the following possible competencies:

- Investigate
- Communicate/public messaging/risk communication
- Activate and adhere to the plan (manage surge, team-based performance, etc.)
- Evaluate activities
- Adjust response
- Minimize impact/manage risk
- Anticipate recovery needs/demobilization plans

Under **Recover (R2)**, the members loaded the following possible competencies:

- Restore critical services (water, food, etc.)
- Restore infrastructure
- Augment plan and response capabilities/disaster resilience
- Evaluate/identify follow-up needs of affected subsets of the population

#### **Recommendations for Future Workgroups**

- Focus on public health practice

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- Make sure the competencies are measurable in terms of educational outcomes, practice outcomes, and/or effectiveness outcomes
- Reference cross-cutting competencies across domains
- Map levels of performance and public health operations/functions to each competency
- Note that the public health foundational skills apply variably to the domains/competencies

**Attachment B: Breakout Group B**

**Day 1**

1. Existing models
  - a. ASPH models do not match target audience of this project
  - b. **Definite overlaps in Council of Linkages model**
  - c. CDC model is arranged by area of practice (pre-response)
    - i. **Should competencies be done by identity or function in time of an emergency?**
      1. **Disaster response is not necessarily related to professional skills**
      2. An interdisciplinary, lower level exists
    - ii. What skills are needed to adequately respond, and who would be responsible for those skills within an organizational structure?
      1. *Preparedness* competencies may be different from *response* competencies
  - d. Best structure should be useful at a workable level
  - e. **Council of Linkages domains-** and other s, i.e. clinical, laboratory
    - i. Integration of systems- ?dimensions of practice
2. Might broad competencies lead to role-based trainings, as the need is exposed?
  - a. Yes, already begun in some capacity, but must make it relevant in order to inspire the buy-in
  - b. Must fit into existing local public health departments' organization, and embrace many disciplines (nursing, etc.)
3. **What categories are important>**
  - a. **Dryfus model: one common language, nothing better**
4. Resources
  - a. ESF-8: scoping question
  - b. AHRQ Interdisciplinary model/NIMS and HSPD-21: Implementation of PAHPA par. 37/38 (reference documents)
  - c. Resource Typing/FEMA
  - d. 2005 NACCHO Report
  - e. APTR Clinical competencies
5. Tenets
  - a. "Followership"- ability to distinguish who is a leader and when
    - i. know when to lead/follow
    - ii. in the event, leadership is constantly changing, follow chain of command
  - b. leadership play a large role in **Planning**
6. Target Audience
  - a. Level of professional?
    - i. Practitioners with BS or higher
    - ii. **Dr. Daniel Sosin Model- not specified level**
  - b. Goals of medical vs. public health preparedness- different but important, model should be all-inclusive
    - i. Medical- individual

1. Support offsite care away from typical care sites
  2. Supplement care providers- supply in the case of increased demand
  3. Optimize patient distribution and transportation
- ii. Public Health
1. Inform clinical environment regarding unique/unusual conditions
  2. Prevent/reduce medical surge, inform public to reduce “worried sick” surge

## Day 2

After attempting to list important core competencies under the 4 proposed domains, Group B concluded that the domains were not working, because if one or more core competencies appear within more than one domain, then those domains cannot, in fact, be considered true domains. Group B then decided to simply list all necessary core competencies and then go back and refit them into new domains.

### Group B Proposed Core Competencies

(Listed under prevent, protect, respond and recover on flipcharts, but do not necessarily fit within these domains)

- Plan/preparation
- Communicate
- Laboratory Support
- Surveillance/Data Analysis (threat identification)
- Health Education
- Team Building/Cooperation Skills
- Respond to indentified threats (clinical/public health assessment and intervention)
- Test response capabilities
- Containment
- Manage Resources
- Safety and Security ( i.e. Environmental, Agriculture/Food, Occupational Health, Work Force Protection)
- Leadership/team building/interactive skills
- Evaluation/ After Action Reviews
- Restore basic health services
- Fatality management
- Financial planning
- Threat countermeasures

### Group B Proposed Domains

- Planning
- Communication
- Risk Management and Mitigation
- Community Preparedness and Participation

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- Intelligence and Information Sharing and Dissemination (includes Surveillance and Analysis)
- Cultural Competency
- Public Health Law and Ethics

## **Attachment C: Breakout Group C**

### **Day 1**

**The flipcharts include the following information:**

#### **Tenets and Guidelines**

*Missing tenets 1-5*

- Align the competencies with the TCLs and the disaster management cycle
- Assure that the common/cross-cutting competencies cut across public health and clinical care
- Indicate three performance levels
- Reflect a population health approach to disaster response
- Target individuals who serve a role in the public health emergency response system
- Supplement existing models

#### **Prior Efforts/Frameworks/Models to Reference**

- AMA disaster medicine competencies
- Council on Linkages competencies

#### **Target Audience**

A la CDC, target:

- “Field” responders
- EOC staff
- Leaders/liaisons

\* and include resource typing

#### **Performance Levels**

Basic, intermediate, and advanced

#### **Potential Domains**

- Planning
- Communication
- Training (exercises and workforce readiness)
- Detection and monitoring
- Collaboration (team participation and team management)
- Risk management (safety and security)
- Leadership
- Incident management

These domains should be linked to the TCL mission areas.

### **Day 2**

Group members decided, after much discussion, that the TCL mission areas did not serve to provide a framework for the competencies. Nevertheless, their initial lumping of

competencies into each mission area follows (with an asterisk by the italicized domains that emerged after further analysis??):

### **Prevent**

- Surveillance
- *\*Planning*
- Working as an interdisciplinary team
- Exercising
- Developing policies and procedures
- Having a working knowledge of public health emergency laws
- Implementing procedures for detection, containment, and response
- Developing public health interventions and measures
- Utilizing partners and networks

### **Protect**

- *\*Detection and monitoring*
- Containment
- Reporting and communicating
- Mitigation
- Outbreak investigation
- Laboratory work
- Personal protective equipment and measures

### **Respond**

- Indications and warning capability
- Monitor response
- Maintain and share situational awareness
- Epidemiology
- Manage within the incident command system
- Risk communications
- *\*Manage risks*

### **Recover**

- Debriefing the event
- Evaluate (well, not well, different)
- Improvement plan
- Resiliency
- Assess community needs/Assess damage
- Restock and recharge

Members noted that the domains identified are not exhaustive and that changes are anticipated.