Appendices

APPENDIX XI: Annotated Bibliography

Allegrante, J.R., Moon, R. W., Auld, E. M., & Gebbie, K. M. (2001). Continuing-education needs of the currently employed public health education workforce. *American Journal of Public Health*, 91(8), 1230-1234.

This article examined the needs of people currently employed in the public health education workforce. A panel was created to identify skills and competences that currently employed individuals in the public health workforce needed in order to effectively practice. The panel identified areas of critical competence that must be strengthened. These areas include computing and technology; business management and finance; communication; strategic planning; coalition building and leadership; evaluation; community health planning and development and cultural competence.

Amodeo, A.R. (2003). Commentary: Developing and retaining a public health workforce for the 21st century: Readiness for a paradigm shift to community-based public health. *Journal of Public Health Management Practice.* 9(6), 500-503.

This commentary describes different efforts to reform the public health system and bring public health and medicine closer together. It profiles initiatives in California that link health departments and community-based organizations in an effort to improve community health, and recommends that further work be done in showing that community collaborations is a necessary next step to improve the health of communities.

Andrulis, D. Delbanco, T. Avakian, L. and Shaw-Taylor, Y. Conducting a Cultural Competence Self-Assessment.

This article provides an overview and purpose for conducting an audit of an organization's cultural competence as well as the steps to follow in the self-assessment process. The authors identify 5 steps: Organization, Competing the Questionnaire (included in the article), Interviews, Evaluation of Results, and Report and Action. This article will help an organization evaluate where it sits within a "spectrum of cultural competence."

**This article includes questions for interviews as well as a cultural competence questionnaire.*

Betancourt, J.R., Green, A.R., & Carrillo, J.E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. *The Commonwealth Fund,* 1-27.

This article underscores the importance of cultural competence strategies as a way to address the disparities in access to and quality of health care across different racial and ethnic groups, and identifies barriers to culturally competent care. The authors conducted site visits to an academic, government, managed care and community health care programs to compare and contrast different models of cultural competence health care. The article includes detailed recommendations to achieve organizational cultural competence and systematic cultural competence drawn from research and site visits.

Brach, C. & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review.* 57, 181-217.

This article identifies nine major cultural competency techniques which form a framework for how the health field can combat the negative health consequences that result from inadequate or no cultural competence. The techniques are: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The authors posit that cultural competency measures such as their nine techniques reduces racial and ethnic health disparities, but they note that further experimental study must be done.

Davies, H.T., Nutley, S.M., & Mannion, R. (2000). Organizational culture and quality of health care. Quality and Safety in Health care. http://qhc.bmjjournals.com/cgi/content/full/9/2/111. 2006 July 18.

With authors based in the UK health system, this article gives a perspective on how health care reform is being discussed outside of the USA. The authors assert that systemic change is necessary in order to improve the quality of healthcare, specifically by honoring the diversity of healthcare consumers and diversity in organizational culture. However, the authors propose that in order to revolutionize the quality of health care through cultural transformation, more specificity is needed regarding what type of organizational culture is most desirous.

Deschaine, J., E., & Schaffer, M.A. (2003). Strengthening the role of public health nurse leaders in policy development. *Policy, Politics, & Nursing Practice,* 4, 266 – 274.

This qualitative study identified and analyzed factors that affect public health nurses leaders and their ability to influence public health policy development. Factors that were examined, included political competencies, barriers to effective policy making, leadership support systems, and knowledge of the health policy-making process. Results indicated support for Longest's model of focusing on three phases of the public policy-making process. This includes policy formulation, policy implementation, and policy modification. Recommendations from this study include supporting growth in leadership and political competence, research skills, and preparation in policy development.

Dreachslin, J.L. (1999). Diversity leadership and organizational transformation: Performance indicators for health services organizations. *Journal of Healthcare Management,* 44(6), 427-439.

Based on case study research that document strategies of health service organizations striving to achieve competitive advantage through market positions as (racial and ethnic) diversity leaders, this article defines 5-part process and behaviorally based performance indicators for each. Some of the indicators described in this article are are pertinent to the Matrix of Workforce Competencies and Organizational Characteristics.

Goode, T.D., Jones, W., & Mason, J. (2002). A guide to planning and implementing cultural competence organizational self-assessment. *National Center for Cultural Competence, Georgetown University Child Development Center,* 1-6.

This article posits that in order to improve services in a culturally competent manner, tools are needed to assess the attitudes and needs of administrators, service providers and consumers. The National Center for Cultural Competence advocates for self-assessment as a means to accomplish this, and they outline the benefits of self-assessment, five guiding principles of self assessment, and steps for planning and implementing self-assessment.

Handler, A., Iseel, M., & Turnock, B. (2001). A conceptual framework to measure performance of the public health system. *American Journal of Public Health,* 91(8), 1235-1239.

This article presents ways to facilitate the measurement of public health system performance by using a unifying conceptual framework. An expert panel along with the Public Health Practice Program Office of the Centers for Disease Control and Prevention (CDC) developed this framework that consists of 5 interrelated components. These components are mission, structural capacity, processes, macro context, and outcomes. The article concludes that such an interconnected conceptual framework is recommended in order to provide a scientific base of the performance of the public health system performance.

Hutchinson, K.D., & Turnock, B.J. (2000). Feasibility of linking core function-related performance measures and community health outcomes. *Center for Public Health Practice,* 1-33.

This article examines the core function-related performance of Illinois local health jurisdictions in order to develop a methodology for examining relationships between public health practice and actual community health outcomes.

Potentially generalizable findings include:

- Core function-related performance is dynamic and is sensitive to changes in local health jurisdiction leadership as well as the time cycle of the IPLAN (Illinois Project for Local Assessment of Need) process.
- Outcome measures that are sensitive to short-term interventions tend to be of greater value in linking local health jurisdiction core function-related performance to health outcomes.
- Impact measures and short-term outcome measures will be more useful in examining links between public health practice performance and community health outcomes than crude death rates.

The authors were unable to identify any positive association and suggest the need for further research on methods for examining the relationship between practice and health outcomes.

This article provides an assessment of Illinois's Project for Local Assessment of Need that links public health agencies with community partners in community health assessment and planning.

**There is some overlap in indicators used with the broad skills areas in the BARHII matrix*

Examples: includes community input and participation, analyze for determinants of health problems, incorporate public participation in planning, agency strategic plan is linked to community health action plan.

Iton, A. Transforming Public Health Practice to Address Health Inequities: Communicating with Staff. 2006 NACCHO annual conference.

This PowerPoint presentation includes the information from the Alameda County Health Status Report 2006 that explores health inequities and provides ways for ACPHD to address those inequities.

**The presentation includes BARHII's own conceptual model of the factors influencing health inequities.*

Lichtveld, M.Y., & Cioffi, J.P. (2003). Public health workforce development: progress, challenges, and opportunities. *Journal of Public Health Management Practice,* 9(6), 443-450.

This article summarizes The Third Annual Public Health Workforce Development Meeting that was held in January 2003 to facilitate implementing a national action agenda to strengthen the public health infrastructure. The framework for action consists of 6 elements which include identifying competencies, developing related curriculum, monitoring workforce composition, providing individual and organizational incentives to ensure competency development, designing an integrated life-long learning delivery system, conducting evaluation and research and assigning financial support. Priorities for competency development within the field were reached due to the meeting.

Kretzmann, J. & McKnight, J. (1993). Building communities from the inside out: A path towards finding and mobilizing a community's assets. Institute for Policy Research at Northwestern University-Evanton, IL.

This guide examines how troubled communities within the United States have become successful with the help of their local leaders. The authors of this guide refer to the process used for these community transformations as "asset-based community development" in which leaders focus on the strengths of their communities and ask them what they can do to help, in contrast to what does the community need. The guide provides summaries of lessons learned from community building initiatives within the United States that have been successful. In addition, suggestions are provided about what local communities can start to do to begin their own asset-based developmental changes.

Magyary, D.L., & Brandt, P. (2005). A leadership training model to enhance private and public service partnerships for children with special healthcare needs. *Infants and Young Children,* 18(1), 60-71.

This article provides an assessment of a Department of Health and Human Services (DHHS) nursing training grant model of leadership for private-public partnerships in area of children with special healthcare needs. The training

grant's culturally competent leadership model includes dimensions of multicultural competency, complexity of human development and diversity, and social-political responsibility and activism. Cultural competence is a necessary leadership quality in order for the 4 levels of health care services from the Maternal Child Healthcare Service Pyramid model to be successful.

Mayer, J.P. (2003). Are the public health workforce competencies predictive of essential service performance? A test at large metropolitan local health department. *Journal of Public Health Management Practice,* 9(3), 208-213.

This article examined the association between competency and essential service job performance within the public health workforce. In 1999, 420 employees of local health departments participated in a cross-sectional survey. The survey consisted of cultural, program development, analytic and communication competencies that were adapted from a report that was an early version for the Council on Linkages competency set (this was before the 2001 official release of the instrument). The framework for job performance measures was created using ten essential services of public health. The Lewin group report commissioned by the Assistant Secretary of Health for Program Evaluation of the U.S. Department of Health and Human Services was used as bases for four to nine items represented in each essential service. Support for core competencies as a foundation for training program content was found, however a larger role of other organizations, individuals and community influence was also accounted for.

**This article includes three cultural competency questions as part of their survey for competency measurement.*

Mays, G. P., McHugh, M. C., Shim, K., Perry, N., Lenaway, D., Halverson, P. K., & Moonesinghe,R. (2006). Institutional and Economic Determinants of Public Health System Performance. *American Journal of Public Health,* (96)3, 523- 531.

This article examines how the institutional, financial, and community characteristics of local public health delivery systems affect the availability and quality of public health services. The authors use multivariate, linear, and nonlinear regression models that showed significant effects of public health system size, financial resources, and organizational structure on the performance of those systems. Staffing levels and community characteristics also affected performance of selected services. The authors recommend improving performance by reconfiguring the organization and financing of public health systems through consolidation and enhancement of intergovernmental coordination.

McAlearney, A.S., Fisher, D., Heiser, D., Robbins, D., & Kelleher, K. (2005). Developing effective physician leaders: Changing cultures and transforming organizations. *Hospital topics: Research and Perspectives on Healthcare,* 83, 11–18.

The cultures of clinical care and organizational management often clash. Medical culture emphasizes autonomous, reactive, quick decision-making that is focused on individual patients whereas managerial culture emphasizes collaboration and pro-active problem-solving that is systems-oriented. These differences are largely a result of different types of training and different methods of advancement in each field. This article examines how one successful physician leadership development program promotes transformational organizational change by educating physicians about organizational leadership. The assessed program included the components of careful curriculum design, program monitoring, and opportunities to apply new skills in practice.

Ministry for Children and Families. Cultural Competency Assessment Tool. Vancouver Ethnocultural Advisory http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm

This article is a comprehensive tool intended to assist the Vancouver region of the Ministry for Children and Families and community based agencies of all sizes in the Vancouver area in becoming more culturally competent. The tool is meant to be used as a way to identify strengths and weaknesses, and to develop an action plan for improvement.

**This article includes a cultural competence assessment tool.*

National Association of County and City Health Officials (2006). Tackling health inequities through public health practice: A handbook for action. Retrieved June 30, 2007, from Alameda County Public Health Department Website: http://www.acphd.org/AXBYCZ/Admin/DataReports/ood_naccho_handbook.pdf

This publication provides a variety of suggested approaches to help transform the public health departmental structures, public health practice and the inequalities in health practices due to various social conditions. The document focuses on restructuring the culture, organization, and daily work of people in the public health field. Cases studies and a conceptual framework are presented to help local health departments be prepared to face challenges from a social justice perspective.

Organizational Self Assessment subset of the AIDS Education and Training Center (AETC) Cultural Competence and Multicultural Care Workgroup. Cultural Competency Organizational Self Assessment (OSA) Question Bank.

This question bank is founded primarily on the Culturally and Linguistically Appropriate Services (CLAS) standards in healthcare as published on December 22, 2000. The OSA subgroup reviewed hundreds of questions included in the Department of Health and Human Services, Office of Minority Health (OMH) guide for implementing CLAS standards, identified questions most appropriate to AETC work, and chose a small number of questions to include in the final version of the Cultural Competency OSA Question Bank. Questions were grouped into themes that became the six modules in this Question Bank.

This article includes cultural competency questions grouped into six modules: Client and Community Input, Diverse and Culturally Competent Staff, Evaluation and Data Management, Language and Interpreter Services, Organizational Policies and Procedures, and Client and Provider Relations.

Potter, M.A., Ley, C.E., Eggleston, M.M., & Dunman, S. (2003). Evaluating workforce development: Perspective, processes and lessons learned. *Journal of Public Health Management Practice,* 9(6), 486-495.

This article summarizes an evaluation of a competency based on a training course in an urban health department. Due to the high interest in five stakeholders (public health agencies, federal funders, trainers, academic research and trainees) The evaluation consisted of a baseline assessment of organizational capacity by agency, demographic data on trainees, pre/post training inventory beliefs and attitude followed by post-training satisfaction survey, 9 month post-training survey and discussion of learning usefulness and organizational impact as desired by academic research and trainers.

Poulton, B. & McCammon, V. (2007). Measuring self-perceived public health nursing competencies using a quantitative approach. *Nurse Education Today,* 27, 238–246.

Public health nurses make invaluable contributions to the field of public health. While much attention has been paid to developing competency frameworks and theory related to public health nursing, tool development for the self-assessment of those competencies has been neglected. This article tests a self-assessment tool for public health nursing competencies on a cohort of nursing students in the United Kingdom. Students completed pre- and post-program self-assessments. Results indicate significant improvements in students' self-perceived public health competencies after completing the program. The authors conclude that their tool is valid for self-assessment of public health nursing competencies.

Putsch, R., SenGupta, I., Sampson, A., & Tervalon, M. (2003). Reflections on the CLAS standards: best practices, innovations and horizons.

This article investigates five public health sites to report on best practices in the field that are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Profiles of the five sites illustrate how organizations bring CLAS standards to life through innovative community-specific practices.

Best practices include:

- Community-driven programs with community control
- Providing linguistically appropriate care to Limited-English Proficiency (LEP) and English speaking populations; historical and contextual diversity find many forms of linguistic expression. For this reason, programs often consider background, life experience and culture in matching programs, providers and patients.
- Themes of relationship and trust raised and woven into programs

Putsch, R.W. & Pololi, L. (2004). Distributive justice in American healthcare: Institutions, power, and equitable care of patients. *The American Journal of Managed Care,* 10, 45-53.

This article examines the widespread inequality in the American healthcare system, which may be permitted and supported by institutional structures, and the inequalities based on race, gender, ethnicity and poverty. Factors that contribute to these inequalities include institutional power and cost and finance of American healthcare. Bias made in decision making by healthcare practitioners, clinical training environments linked to abuse of patients and coworkers, politics and healthcare provider ethnicity increase these inequalities within the healthcare system.

Scutchfield, F.D, Knight, E., Kelly, A.V., Bhandari, M.W., & Vasilescu, I.P. (2004). Local public health agency capacity and its relationship to public health system performance. *Journal of Public Health Management Practice,* 10(30), 204-215.

Local public health agency capacity characteristics that are related to local public health systems' performance scores on the CDC's National Public Health Performance Standard Program assessment instrument were identified in this article. A sample of 152 jurisdictions were obtained from three states performances scores from a test version of the National Public Health Performance Standards instrument (5b) from county and city/county jurisdictions that were matched to organizational capacity data from the 1997 National Association of County and City Health Officials profile of health departments. Results indicated that public health agency capacities in areas of organizational leadership, funding, and certain non-provider partnerships were significantly related to public health system performance.

National Standards for Culturally and Linguistically Appropriate Services in Health Care. (2001). U.S. Department of Health and Human Services Office of Minority Health.

This report outlines 14 different standards for health care providers that would support a consistent and comprehensive approach for a more culturally and linguistically competent health care system. These 14 standards include themes such as Culturally Competent Care (Standards 1 -3), Language Access Services (Standards 4 – 7), and Organizational Supports for Cultural Competence (Standards 8 – 14).

Weech-Maldonado, R. (2002). Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management,* 47(2), 111-126.

Data in 2000 were pulled from the National Consumer Assessment of Health Plans (CAHPS) Benchmarking Database 3.0 to examine adults enrolled in Medicaid managed care plans in 14 states. The study examined whether race/ethnicity and language varied consumer reporting and rating of care of Medicaid managed care plans. Items examined included global rating items such as personal doctor, health care, health plan, and specialists. Multi-items reports of care such as getting needed care, provider communication, plan service, staff helpfulness, and timeliness of care were also rated. Overall, adults who were racial/ethnic and linguistic minorities reported receiving worse care than whites. Worse care was also reported for those who were linguistic minorities compared to those who were racial/ethnic minorities. The authors recommend that quality improvement efforts should be made in disparities in access to care for linguistic and racial/ethnic minorities.

Wright, K. et al. (2003). Health education leadership development: A conceptual model and competency framework. *Health Promotion Practice,* 4(3), 293-302.

This article includes a model and framework for the Public Health Education Leadership Institute, a 15-month professional leadership development program aimed at senior level health educators. Institute created through collaboration among national health education professional organizations, CDC, and a school of public health.

> **Many similarities to BARHII Matrix in leadership competencies, innovation, collaboration skills, cultural competencies, communication, and staff support.*
>
> *Some parallels with BARHII Matrix in community knowledge, and understanding determinants of health inequities.*

Wright, K. Rowitz, L. Merkle, A. Reid, W. M. Robinson, G. Herzog, B. Weber, D. Carmichael, D. Balderson, T. R. Baker, E. Competency Development in Public Health Leadership. *American Journal of Public Health.* 2000 August; 90(8): 1202–1207.

This article discusses the creation of the National Public Health Leadership Development Network (NLN), a consortium of institutes providing a system of leadership development, and reviews the network's creation of the Leadership Competency Framework for core curriculum design and development of performance standards for public health practice.

Other Resources

National Association of County and City Health Officials
http://www.naccho.org/

The Center for Health Equity, Louisville Metro Department of Public Health and Wellness
http://www.louisvilleky.gov/Health/equity/

National Center for Cultural Competency, Georgetown University
http://www11.georgetown.edu/research/gucchd/nccc/foundations/assessment.html
Cultural and Linguistic Competence Policy Assessment (CLCPA): Instrument and Guide
Health sector reform and public sector health worker motivation: A conceptual framework. (2002, April), by L. M. Franco, S. Bennett, and R. Kanfer, Social Science Medicine, Volume 54, No. 8, 1255-1266.

American Public Health Association – Exploring Accreditation
http://www.exploringaccreditation.org/documents/EAFinalRecommendations9-29.pdf
http://www.apha.org/searchresults.htm?query=accreditation

Public Health Infrastructure Resource Center
http://www.phf.org/infrastructure/