ASPH Education Committee

Doctor of Public Health (DrPH) Core Competency Model

Version 1.3

November 2009




ASPH
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Association of Schools of Public Health
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Dear Colleague,

The Association of Schools of Public Health (ASPH) is pleased to present the Doctor of Public Health (DrPH) Core Competency Model Version 1.3. These competencies represent a national, expert panel effort undertaken between 2007 and 2009 by over 200 members of the academic and practice communities under the jurisdiction of the ASPH Education Committee, chaired by Dean John Finnegan (Minnesota). In releasing this model, ASPH aims to stimulate a national discussion on the competencies needed by DrPH graduates in light of the new challenges of 21st century public health practice and, thus, to define better the DrPH degree.

Included in the Core Competency Model are 54 competencies in seven domains (Advocacy, Communication, Community/Cultural Orientation, Critical Analysis, Leadership, Management, and Professionalism and Ethics).

This competency model is intended as a *resource* and *guide* for those interested in improving the quality and accountability of graduate public health education and training, not as a prescriptive model. For programs interested in adopting some or even all of the specified core competencies, ASPH is not prescribing the method nor the processes for student achievement of the competencies, nor techniques for faculty to implement the competencies. ASPH recognizes that the implementation of the competencies will likely vary as a function of each school's mission and goals for their DrPH program.

ASPH anticipates that the competency model may also be useful to colleagues at graduate public health programs, employers, and practice and agency partners.

We are extremely grateful to the many leaders who participated in the competency development process and especially Dr. Judith Calhoun, the project's faculty consultant, for the expertise and time committed to the project.

Other competency-related resources are available at www.asph.org/competency. Feedback is welcome and can be provided at DrPHcompetency@asph.org. It is understood that competency models generally have a limited lifespan and that the model should be examined and updated as new thinking and future challenges evolve in the field. We recommend that the model be reviewed frequently at local and national levels with personnel from agencies and organizations where graduates are employed.

Sincerely,

James Raczynski, PhD
Chair, DrPH Competency Development Project
Founding Dean, Fay W. Boozman College of Public Health
University of Arkansas for the Medical Sciences

Linda Rosenstock, MD, MPH
Chair, ASPH Board of Directors
Dean, School of Public Health
University of California at Los Angeles

Introduction to the Model

The Association of Schools of Public Health (ASPH)[1] Education Committee charged Dean James Raczynski (University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health) in 2007 with developing a model of core competencies for future DrPH graduates. From 2007 to 2009, using an expert panel approach, ASPH developed the Doctor of Public Health (DrPH) Core Competency Model as presented in Version 1.3. Created through a modified Delphi process, the DrPH Core Competency Model identifies teachable, observable, and measurable skills for DrPH graduates.

Over 200 academic and practice participants crafted this model as a resource and guide for developing and improving DrPH programs and curricula. Seven workgroups produced a set of 54 DrPH core competencies covering seven domains of skills all DrPH graduates, regardless of specialization, should be able to perform upon graduation. The domains include:

- Advocacy
- Communication
- Community/Cultural Orientation
- Critical Analysis
- Leadership
- Management
- Professionalism and Ethics

See Appendix 1 for the domains, domain definitions, and competencies and Appendix 2 for the graphic model. Appendix 3 references the domains and domain definitions.

The DrPH core competency model is the first national set of recommended competencies for the DrPH degree which highlights the transformative leadership role DrPH graduates play in public health research and practice, as well as in advancing the field. It is not prescriptive to ASPH-member schools and is put forward as a benchmark for schools to use in creating or rethinking DrPH programs. The model will be examined and updated as new thinking and future challenges evolve in the field.

Rationale

The DrPH competency development initiative formally began in 2007 as a result of the:

- Renewed efforts by ASPH members to better define the Doctor of Public Health degree
- Challenges of 21st century public health practice and practice-based research
- Proliferation of competency-based training in academic public health
- Recommendations by important national organizations (e.g., Institute of Medicine)
- Greater emphasis on accountability in higher education

Brief ASPH History of Defining the DrPH Degree

1994:	Commissioned “An Analysis of DrPH Degree Programs in the United States”
2003 June:	Presented “Review of the Status of the Doctor of Public Health (DrPH) Degree at ASPH” at the Associate Deans for Academic Affairs’ retreat

[1] The Association of Schools of Public Health (ASPH) represents the current 43 schools of public health accredited by the Council on Education for Public Health (CEPH). The CEPH-accredited schools of public health are located in the United States, Puerto Rico, and Mexico.

2006 November:	Hosted first DrPH meeting for all interested members
2006 December:	Developed DrPH Main Committee and DrPH Steering Committee as sub-committees under the Education Committee
2007 May:	Held DrPH discussion at Education Committee Spring Meeting
2007 January-June:	Drafted consensus statements on DrPH degree
2007 November:	Hosted DrPH Consensus Conference to launch the competency development process with both academic and practice representatives
2008 February:	Held Concept Identification and Specification Task Force Meeting with both academic and practice representatives
2008 May-June:	Populated workgroups with both academic and practice representatives
2008 July:	Began modified Delphi process
2009 March:	Conducted Competency Integration Council Meeting
2009 April-October:	Release of draft models and reviews by ASPH bodies and external partners
2009 November:	*ASPH Board of Directors' approval of Version 1.3 [pending]*

Defining the DrPH Degree

The ASPH DrPH Steering Committee worked together to define the DrPH degree for purposes of building consensus on the issue. They came to initial agreement that both the Doctor of Philosophy (PhD) and DrPH degree programs should prepare graduates for research careers, PhD training typically trains graduates to focus their research in narrowly defined areas, while the DrPH should be the advanced professional degree designed to prepare individuals for public health evidence-based leadership and practice-based research roles

The steering committee drafted a "Consensus Statement About DrPH Programs" over the course of several months early in 2007. This statement reflects early discussions about key aspects of DrPH programs which were considered relevant to the competency development process. It follows:

ASPH DrPH Steering Committee
DRAFT Consensus Statement about DrPH Programs[2]
June 26, 2007

There is consensus that "the basic public health degree is the master of public health (MPH), while the doctor of public health (DrPH) is offered for advanced training in public health leadership."[3]

The DrPH curriculum should serve to integrate the five core areas of public health, emphasize work experience relevant to the degree, and address learning methods in the context of public health practice. The DrPH should represent an advanced competency in public health practice and leadership skills, among others.

[2] Adapted from: Lee JM, Furner S, Yager J, Hoffman D. Review of the Status of the Doctor of Public Health (DrPH) Degree. A presentation summarizing discussions of the associate deans from the ASPH member schools, 2003.

[3] K Gebbie, L Rosenstock, and LM Hernandez, Editors. Board on Health Promotion and Disease Prevention, Institute of Medicine. Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century. The National Academics Press. 2003

DrPH programs should ensure that graduates have experiences in collaborating with senior public health practitioners through some form of practicum or other means. This experience should be an opportunity to observe and to develop advocacy and leadership skills.

There should be a doctoral thesis/dissertation requirement for the DrPH. The thesis should be a written product that addresses, generates, and/or interprets and evaluates knowledge applicable to practice.

In developing these competencies, the DrPH Core Competency Model developers emphasized the need to focus research training in DrPH programs on practice-oriented research and scholarship in keeping with the professional practice focus of the degree. Such scholarship, as previously defined by ASPH, is considered "not only the science implicit in academic public health practice, but its application through research, teaching, and service (the art of practice), that builds skill in adapting things in the natural world to improve human life."[2] The resulting model represents DrPH degree holders as leaders in the field of public health who use advanced research expertise to develop and implement evidence-based public health practice using advocacy, communication, community/cultural orientation, critical analysis, management, and professionalism and ethics skills. Leadership is viewed as the nucleus of the seven domains.

Nonetheless, the committee recognized an important tenet guiding the process is the reality that the DrPH is offered in a wide variety of forms, with a broad range of content, at academic institutions across the United States. Accordingly, the DrPH Core Competency Model is not intended to prescribe DrPH education but is posited to provide assistance to those schools of public health in developing new or reformulating existing DrPH programs. The model is also intended to represent only the core competencies for the DrPH, recognizing that individual schools of public health will supplement these core competencies with additional ones to reflect their program focus.

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[4] The quotation can be found in Demonstrating Excellence in Practice-based Research for Public Health, published by the ASPH Council of Public Health Practice Coordinators and available at: http://www.asph.org/document.cfm?page=600.

Identification of Domains

In November 2007, Dean Raczynski convened a Consensus Conference in which participants from academe and practice identified workforce needs and employment opportunities for DrPH holders as well as began the process of identifying preliminary competency domains and core constructs for each initial DrPH domain. Subsequently, in February of 2008, Dean Raczynski drew upon inputs provided at the November meeting in leading the DrPH Concept Identification and Specification Task Force Meeting. Participants in both meetings are listed in Appendix 4 as Model Development Contributors.

At the February 2008 meeting, the 21 attendees were divided into four groups and charged to:

1. Provide input regarding potential competency domains, if applicable, for the identified core competencies
2. Identify 6-12 core competencies essential for success as a DrPH
3. Specify 4-6 behaviorally-based and measurable sub-competencies that would indicate proficiency in each core competency
4. Identify model development process considerations for future workgroups

An advisory panel of six members was chosen from the attendees of the February 2008 meeting. Using input from the February 2008 meeting, the advisory panel was charged to:

1. Select competency domains to guide future model development work
2. Finalize six-10 core competencies for DrPH success reflective of consensus planning to date
3. Define the domains and core competencies for submission to the model development workgroups for subsequent refinement
4. List key suggestions/recommendations for guiding workgroup model development activities
5. Provide ongoing review and input for the evolving DrPH competency model

Using input from the advisory panel, Dean Raczynski selected seven preliminary domains to be defined by seven workgroups.

Development of Academic-Practice Workgroups

Project staff consulted with ASPH-member deans and the leadership from three critical partner organizations – the American Public Health Association, Association of State and Territorial Health Officials, and National Association of County and City Health Officials – to identify individuals to serve on the workgroups to develop and refine the competencies. Given the nature of the DrPH degree, practitioners were actively sought.

The workgroups were led by co-chairs with an initial goal of having each co-chair for all workgroups representing the practice and/or academic communities. Membership was composed of approximately equal numbers of practitioners and academics. For six of the seven workgroups, it was possible to identify practitioner co-chairs. Thirty-three percent of the approximately 180 workgroup participants were practitioners. See Appendix 5 for the Workgroup Chairs and Appendix 6 for the Workgroup Members.

Modified Delphi Process to Identify Competencies

Each of the seven workgroups was charged in the summer of 2008 to create an exhaustive slate of competencies. The range of preliminary competencies was 82-190 per workgroup. To distill the large slate of competencies developed by each workgroup at the beginning of their processes to 8-10 competencies per domain, each workgroup completed three Delphi surveys. Each Delphi was followed up by conference calls.

Each domain was assigned 10 core members with other participants as resource members. The 10 core members of each workgroup were asked to complete all three surveys. Resource members of each workgroup were asked to complete the second and third surveys. After each survey, core members discussed the survey results in order to distill and refine the next list of competencies. Table 1 depicts the criteria for acceptance for each of the three rounds of modified-Delphi review process for each workgroup.

Table 1: Criteria for Acceptance of Each Competency in the Modified Delphi Surveys

Delphi 1 and Delphi 2	Delphi 3
1. Accept 2. Accept with changes as noted below 3. Reject 4. Consider an alternative as noted below If "accept with changes," how should it be reworded? If "consider an alternative," please provide it below.	1. Accept 2. Reject 3. Final Comments (use the box below for comments) Final Comments box.

The specific numbers of competencies reviewed during each of the three rounds of Delphi surveys, as well as the response rate from the respective workgroup, are listed in Table 2. The overall response rate of all three Delphi survey rounds was 88%.

Table 2: Summary of Delphi Survey Outcomes

Domain	Delphi 1		Delphi 2		Delphi 3		Competency Integration Council
	No. of Comps	Response Rate %	No. of Comps	Response Rate %	No. of Comps	Response Rate %	No. of Comps
Advocacy	85	90	33	83	18	91	8
Communication	156	100	41	81	19	85	11
Community/Cultural Orientation	102	90	40	81	13	79	8
Critical Analysis	131	100	56	96	21	89	9
Leadership	82	100	37	81	20	74	9
Management	190	90	71	76	18	86	10
Professionalism and Ethics	135	100	49	90	11	95	9
Total	881	---	327	---	120	---	64

Competency Integration Council

The workgroup chairs met in March 2009 to combine the seven domains and 64 competencies into a unified model. The Competency Integration Council was charged to:

- Carefully review preliminary listings from each domain workgroup
- Look at the model holistically
- Consider the set from a national, multi-school and program perspective
- Determine if any DrPH competencies were:
  - Redundant
  - Overemphasized
  - Underrepresented or missing
- Provide input on dissemination and implementation
- Play a leadership role in promoting the model to faculty at schools of public health

The Competency Integration Council was advised to ensure the final competencies are readily observable, measurable, and could be taught. The Council also sought competencies which are critical to transformational leadership in public health and at a high enough level for a DrPH graduate, per Bloom's Taxonomy of Educational Outcomes.

Sixty-four competencies were presented among the seven workgroups at the Competency Integration Council meeting. After substantial discussion, the chairs agreed to whittle down the list to 51 in total.

Vetting, Finalization, and Dissemination of the Model

In April 2009, the workgroup chairs, consultant, and staff finalized the model for vetting by key stakeholders. The ASPH Education Committee and the DrPH program directors separately reviewed the draft model version 1.0 of 51 competencies in May. In June, staff shared the model with the Council on Linkages for Academia and Public Health Practice. Dean Raczynski then presented the model to the ASPH associate deans for academic affairs at their June retreat and to the ASPH deans at their July retreat. Feedback from all these groups was positive. Some reviewers had suggestions for improving the model, and these comments were provided to the workgroup chairs for careful consideration. In September and October 2009, staff worked with Dean Raczynski, the consultant, and the workgroup chairs to refine the model. During the refinement process, competencies related to research were strengthened and three new competencies were added to the model.

Of the 54 remaining competencies, 96% of the competencies are classified in the Cognitive Domain and 4% are classified in the Affective Domain of Bloom's Taxonomy of Educational Outcomes (See Table 3 below).As a result of the comments, minor updates were made and newer versions posted online over time.

Table 3: Classification of Competencies with Bloom's Taxonomy of Educational Outcomes

Bloom's Taxonomic Class	Advocacy	Communication	Community/ Cultural Orientation	Critical Analysis	Leadership	Management	Professionalism and Ethics
Cognitive Domain							
1.0 Knowledge							
2.0 Comprehension		2 (22%)					
3.0 Application	3 (43%)	2 (22%)	3 (50%)	1 (14%)	5 (56%)	6 (67%)	1 (14%)
4.0 Analysis	1 (14%)			1 (14%)			1 (14%)
5.0 Synthesis	3 (43%)	4 (44%)	1 (17%)	4 (43%)	3 (33%)	2 (22%)	3 (44%)
6.0 Evaluation		1 (12%)	2 (33%)	1 (29%)		1 (11%)	1 (14%)
Affective Domain					1 (11%)		1 (14%)
54 Competencies	7	9	6	7	9	9	7

Conclusion

Developers of the DrPH Core Competency Model recognize the dynamic nature of public health and the grounding of the seven cross-cutting competencies in the core public health sciences, as acquired in Master of Public Health (MPH) programs at schools of public health. The model represents DrPH degree holders as leaders in the field of public health who use advanced research expertise to perform and evaluate evidence-based public health practice using advocacy, communication, community/cultural orientation, critical analysis, leadership, management, and professionalism and ethics skills.

It is understood that competency sets generally have a limited lifespan and that the model should be examined and updated as new thinking and future challenges evolve in the field. The model developers recommend that input from personnel who employ DrPH holders be integrated into future thinking regarding the preparation of DrPH graduates.

ASPH staff will continue to disseminate the model at both internal meetings and with partners, both in print and via electronic means. Comments and input on the Doctor of Public Health (DrPH) Core Competency Model are welcomed. Such feedback will assist the ASPH Education Committee in improving future versions of the model so as to enhance training for future leaders in public health. Contact ASPH via the web at www.asph.org or email DrPHcompetency@asph.org with comments.

Appendix 1: DrPH Core Competencies

A. ADVOCACY

The ability to influence decision-making regarding policies and practices that advance public health using scientific knowledge, analysis, communication, and consensus-building.

Competencies: Upon graduation a student with a DrPH should be able to…

A1. Present positions on health issues, law, and policy.

A2. Influence health policy and program decision-making based on scientific evidence, stakeholder input, and public opinion data.

A3. Utilize consensus-building, negotiation, and conflict avoidance and resolution techniques.

A4. Analyze the impact of legislation, judicial opinions, regulations, and policies on population health.

A5. Establish goals, timelines, funding alternatives, and strategies for influencing policy initiatives.

A6. Design action plans for building public and political support for programs and policies.

A7. Develop evidence-based strategies for changing health law and policy.

DrPH Core Competencies *(continued)*

B. COMMUNICATION

The ability to assess and use communication strategies across diverse audiences to inform and influence individual, organization, community, and policy actions.

Competencies: Upon graduation a student with a DrPH should be able to…

B1. Discuss the inter-relationships between health communication and marketing.

B2. Explain communication program proposals and evaluations to lay, professional, and policy audiences.

B3. Employ evidence-based communication program models for disseminating research and evaluation outcomes.

B4. Guide an organization in setting communication goals, objectives, and priorities.

B5. Create informational and persuasive communications.

B6. Integrate health literacy concepts in all communication and marketing initiatives.

B7. Develop formative and outcome evaluation plans for communication and marketing efforts.

B8. Prepare dissemination plans for communication programs and evaluations.

B9. Propose recommendations for improving communication processes.

DrPH Core Competencies *(continued)*

C. COMMUNITY/CULTURAL ORIENTATION

The ability to communicate and interact with people across diverse communities and cultures for development of programs, policies, and research.

Competencies: Upon graduation a student with a DrPH should be able to…

C1. Develop collaborative partnerships with communities, policy makers, and other relevant groups.

C2. Engage communities in creating evidence-based, culturally competent programs.

C3. Conduct community-based participatory intervention and research projects.

C4. Design action plans for enhancing community and population-based health.

C5. Assess cultural, environmental, and social justice influences on the health of communities.

C6. Implement culturally and linguistically appropriate programs, services, and research.

DrPH Core Competencies *(continued)*

D. CRITICAL ANALYSIS

The ability to synthesize and apply evidence-based research and theory from a broad range of disciplines and health-related data sources to advance programs, policies, and systems promoting population health.

Competencies: Upon graduation a student with a DrPH should be able to…

- D1. Apply theoretical and evidence-based perspectives from multiple disciplines in the design and implementation of programs, policies, and systems.
- D2. Interpret quantitative and qualitative data following current scientific standards.
- D3. Design needs and resource assessments for communities and populations.
- D4. Develop health surveillance systems to monitor population health, health equity, and public health services.
- D5. Synthesize information from multiple sources for research and practice.
- D6. Evaluate the performance and impact of health programs, policies, and systems.
- D7. Weigh risks, benefits, and unintended consequences of research and practice.

DrPH Core Competencies *(continued)*

E. LEADERSHIP

The ability to create and communicate a shared vision for a positive future; inspire trust and motivate others; and use evidence-based strategies to enhance essential public health services.

Competencies: Upon graduation a student with a DrPH should be able to…

E1. Communicate an organization's mission, shared vision, and values to stakeholders.

E2. Develop teams for implementing health initiatives.

E3. Collaborate with diverse groups.

E4. Influence others to achieve high standards of performance and accountability.

E5. Guide organizational decision-making and planning based on internal and external environmental research.

E6. Prepare professional plans incorporating lifelong learning, mentoring, and continued career progression strategies.

E7. Create a shared vision.

E8. Develop capacity-building strategies at the individual, organizational, and community level.

E9. Demonstrate a commitment to personal and professional values.

DrPH Core Competencies *(continued)*

F. MANAGEMENT

The ability to provide fiscally responsible strategic and operational guidance within both public and private health organizations for achieving individual and community health and wellness.

Competencies: Upon graduation a student with a DrPH should be able to…

F1. Implement strategic planning processes.

F2. Apply principles of human resource management.

F3. Use informatics principles in the design and implementation of information systems.

F4. Align policies and procedures with regulatory and statutory requirements.

F5. Deploy quality improvement methods.

F6. Organize the work environment with defined lines of responsibility, authority, communication, and governance.

F7. Develop financial and business plans for health programs and services.

F8. Establish a network of relationships, including internal and external collaborators.

F9. Evaluate organizational performance in relation to strategic and defined goals.

DrPH Core Competencies *(continued)*

G. PROFESSIONALISM AND ETHICS

The ability to identify and analyze an ethical issue; balance the claims of personal liberty with the responsibility to protect and improve the health of the population; and act on the ethical concepts of social justice and human rights in public health research and practice.

Competencies: Upon graduation a student with a DrPH should be able to…

G1. Manage potential conflicts of interest encountered by practitioners, researchers, and organizations.

G2. Differentiate among the administrative, legal, ethical, and quality assurance dimensions of research and practice.

G3. Design strategies for resolving ethical concerns in research, law, and regulations.

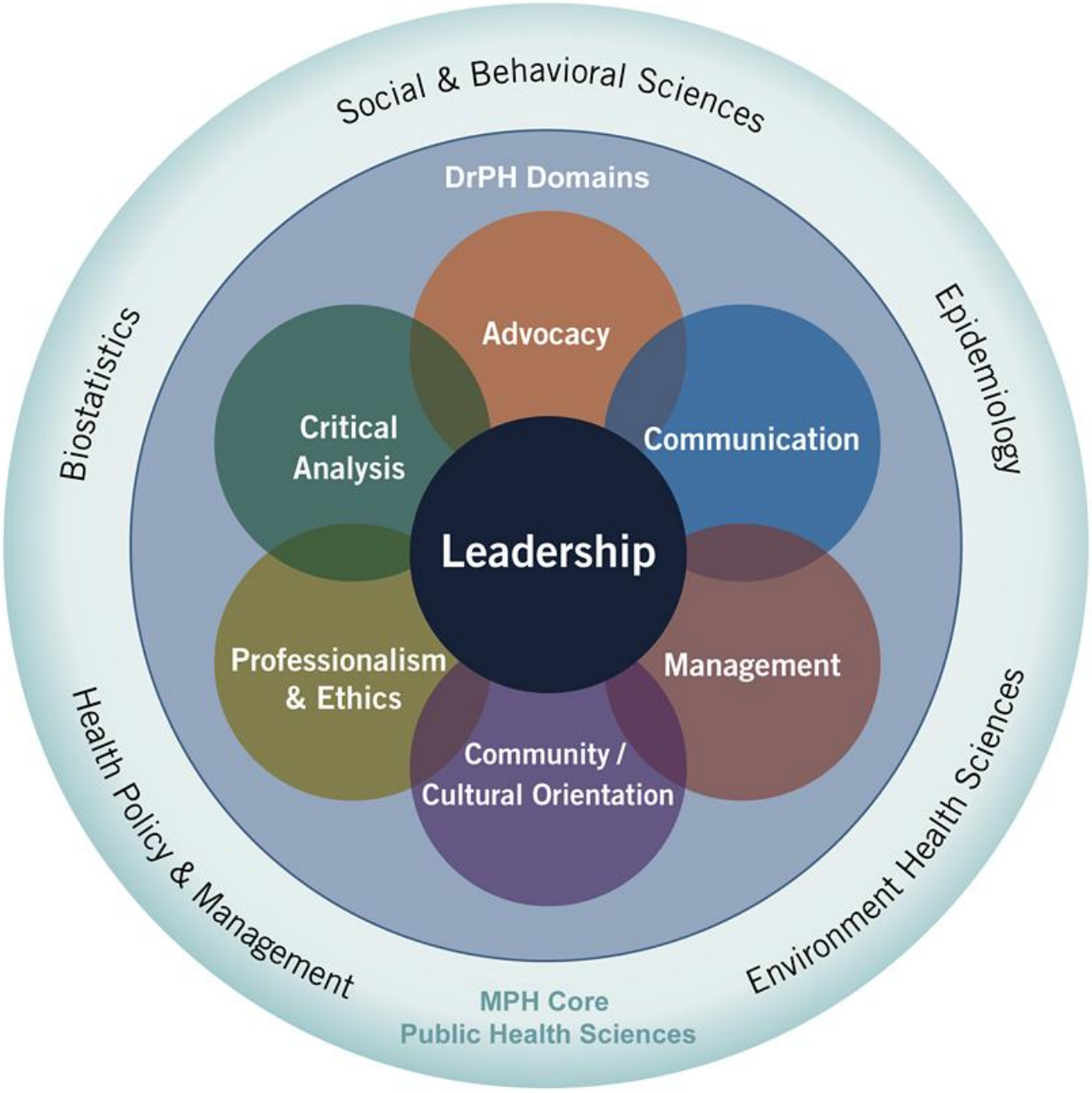
G4. Develop tools that protect the privacy of individuals and communities involved in health programs, policies, and research.

G5. Prepare criteria for which the protection of the public welfare may transcend the right to individual autonomy.

G6. Assess ethical considerations in developing communications and promotional initiatives.

G7. Demonstrate cultural sensitivity in ethical discourse and analysis.

Appendix 2: Graphic of the DrPH Core Competency Model



Appendix 3: Competency Domain Definitions*

ADVOCACY
The ability to influence decision-making regarding policies and practices that advance public health using scientific knowledge, analysis, communication, and consensus-building.

COMMUNICATION
The ability to assess and use communication strategies across diverse audiences that inform and influence individual, organization, community, and policy actions.

COMMUNITY/CULTURAL ORIENTATION
The ability to communicate and interact with people across diverse communities and cultures for development of programs, policies, and research.

CRITICAL ANALYSIS
The ability to synthesize and apply evidence-based research and theory from a broad range of disciplines and health-related data sources to advance programs, policies, and systems promoting population health.

LEADERSHIP
The ability to create and communicate a shared vision for a positive future; inspire trust and motivate others; and use evidence-based strategies to enhance essential public health services.

MANAGEMENT
The ability to provide fiscally responsible strategic and operational guidance within both public and private health organizations for achieving individual and community health and wellness.

PROFESSIONALISM AND ETHICS
The ability to identify and analyze an ethical issue; balance the claims of personal liberty with the responsibility to protect and improve the health of the population; and act on the ethical concepts of social justice and human rights in public health research and practice.

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*Definitions are provided to define the context by which the work groups' competency modeling development activities took place and are not intended to describe the entire field of the particular domain's scholarship and practice.

Appendix 4: Model Development Contributors

Education Committee DrPH Consensus Conference (November 2, 2007 in Washington, DC)

Dean James Raczynski, University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health (Project Chair)

Dr. Linda Alexander, University of Kentucky College of Public Health

Dr. David Altman, Center for Creative Leadership

Mr. J. Maichle Bacon, Winnebago County Health Department, Illinois

Dr. Leona K. Bartholomew, University of Texas School of Public Health

Dr. Harvey Brenner, University of North Texas Health Science Center School of Public Health

Dr. James N. Burdine, Texas A&M School of Rural Public Health

Dr. Cynthia Chappell, University of Texas School of Public Health

Mr. Gary Cox, National Association of County & City Health Officials

Dr. Rick Danko, Texas Department of State Health Services

Dr. Eugene Declercq, Boston University School of Public Health

Dr. Tony DeLucia, East Tennessee State University School of Public Health

Dean John Finnegan, University of Minnesota School of Public Health

Dean Elizabeth T.H. Fontham, Louisiana State University Health Science Center

Dr. Judith Garrard, University of Minnesota School of Public Health

Dr. Barbara Hatcher, American Public Health Association

Dr. Suzanne Havala Hobbs, University of North Carolina at Chapel Hill Gillings School of Global Public Health

Dr. Raymond E. Hill, University of Kentucky College of Public Health

Dr. Paul B. Hofmann, Hofmann Healthcare Group

Dr. Joel Lee, University of Georgia College of Public Health

Dr. D. Patrick Lenihan, University of Illinois at Chicago School of Public Health

Dr. Laura C. Leviton, The Robert Wood Johnson Foundation

Ms. Natalie Levkovich, Health Federation of Philadelphia

Dr. Jane Lewis, University of Medicine and Dentistry of New Jersey School of Public Health

Dr. Amanda Liddle, Georgetown University School of Nursing and Health Studies

Dr. Laura Magaña Valladares, National Institute of Public Health, Mexico

Dr. Jeanette H. Magnus, Tulane University School of Public Health & Tropical Medicine

Dr. H. Virginia McCoy, Florida International University Robert Stempel School of Public Health

Dr. Peter Messeri, Columbia University Mailman School of Public Health

Dr. Jim Meyers, University of California at Berkeley School of Public Health

Dr. Kathleen Miner, Emory University Rollins School of Public Health

Dr. Laura Morlock, Johns Hopkins Bloomberg School of Public Health

Dr. Marina Moses, George Washington University School of Public Health and Health Services

Dr. Beverly Mulvihill, University of Alabama at Birmingham School of Public Health

Dr. Babette Neuberger, University of Illinois at Chicago School of Public Health

Dr. Barbara Orban, University of South Florida School of Public Health

Dr. Tricia Penniecook, Loma Linda University School of Public Health

Ms. Margaret Potter, University of Pittsburgh Graduate School of Public Health

Dr. Silvia E. Rabionet, University of Puerto Rico Graduate School of Public Health

Dr. Barry Sherman, University at Albany SUNY School of Public Health

Dr. Katharine Stewart, University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health

Dr. Doug Taren, University of Arizona Mel and Enid Zuckerman College of Public Health

Dr. Elizabeth Trevino, Baylor Health Care System, Texas

Dr. Lisa Ulmer, Drexel University School of Public Health

Dr. John Williams, University of Kentucky College of Public Health

Concept Identification and Specification Task Force Meeting (February 21-22, 2008 in Atlanta, GA)

Dean James Raczynski, University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health (Project Chair)

Dr. Linda Alexander, University of Kentucky College of Public Health

Mr. J. Maichle Bacon, Winnebago County Health Department, Illinois

Dr. Leona K. Bartholomew, University of Texas School of Public Health

Dr. Cynthia Chappell, University of Texas School of Public Health

Dr. Rick Danko, Texas Department of State Health Services

Dr. Eugene Declercq, Boston University School of Public Health

Dr. Tony DeLucia, East Tennessee State University School of Public Health

Dr. Mary Dott, U.S. Centers for Disease Control and Prevention

Dean John Finnegan, University of Minnesota School of Public Health

Dr. Barbara Hatcher, American Public Health Association

Dr. Suzanne Havala Hobbs, University of North Carolina at Chapel Hill Gillings School of Global Public Health

Dr. Paul B. Hofmann, Hofmann Healthcare Group

Dr. Joel Lee, University of Georgia College of Public Health

Dr. D. Patrick Lenihan, University of Illinois at Chicago School of Public Health

Dr. Richard Levinson, Emory University Rollins School of Public Health

Dr. Laura C. Leviton, The Robert Wood Johnson Foundation

Dr. Laura Magaña Valladares, National Institute of Public Health, Mexico

Dr. Peter Messeri, Columbia University Mailman School of Public Health

Dr. Jim Meyers, University of California at Berkeley School of Public Health

Dr. Kathleen Miner, Emory University Rollins School of Public Health

Dr. Elizabeth Trevino, Baylor Health Care System, Texas

Dr. John Williams, University of Kentucky College of Public Health

Competency Integration Council Meeting
(March 9-10, 2009 in Atlanta, GA)

Dean Carleen Stoskopf, San Diego State University Graduate School of Public Health (Meeting Chair)

Dr. John Baker, University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health

Dr. Daniel Boatright, University of Oklahoma College of Public Health

Dr. Sheree Boulet, U.S. Centers for Disease Control and Prevention

Dr. Tony DeLucia, East Tennessee State University School of Public Health

Dr. Mary Dott, U.S. Centers for Disease Control and Prevention

Dr. Connie Evashwick, Saint Louis University School of Public Health

Dr. Robert Fullilove, Columbia University Mailman School of Public Health

Dr. Lyndon Haviland, Lyndon Haviland and Co, LLC

Dr. Susan Kirby, Kirby Marketing Solutions

Dr. Peter Messeri, Columbia University Mailman School of Public Health

Dr. Edyth Schoenrich, Johns Hopkins University Bloomberg School of Public Health

Dr. David Tollerud, University of Louisville School of Public Health and Information Sciences

Dr. Ximena Urrutia-Rojas, University of Texas School of Public Health

Appendix 5: Workgroup Chairs

The following workgroup chairs deserve many thanks for leading the approximately 180 members of the seven workgroups through the year-long competency identification and specification processes. All represent expert volunteers who invested many hours of time facilitating discussions to reach agreement on the objective, measurable skills needed by DrPH graduates.

ADVOCACY

- Dr. Anthony Delucia (East Tennessee State University Colleges of Public Health and Medicine)
- Ms. Lee Thielen (Colorado Association of Local Public Health Officials)

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