DRAFT ASPPH Response to CEPH, ROUND 4 -- August 19, 2016, for Circulation to ASPPH Members

Changes are indicated in red and/or strikeout

#	Criterion	Line(s)	ASPPH Group(s)	Recommendation(s)/Issue(s)	Rationale/Background/Context/Other
				B. Mission and Evaluation	
1	B4	Data Template B4-1, Row 13	Data Committee & Career Services Forum	The data template, which references CEPH's FAQ document "about collecting and reporting job placement data," needs to be updated to reflect the proposed criteria. Further, the FAQ could include Q&A regarding how a fellowship/internship/residency is considered part of "Employed" even if the student is less than 100% time.	Consistency among the documents, including the FAQ sheet
				C. Resources	
2	C2-B	465-493	Accredita-tion Committee	Revise statement as follows and apply to **both** Schools and Programs: "• Employed full-time as faculty members appointed in the SPH ~~(i.e., 1.0 FTE in the unit of 465 accreditation)~~. For the purposes of accreditation, faculty members appointed in the SPH will be considered employed full-time if they are engaged in SPH faculty activities with at least 0.75 FTE effort for schools using 12-month faculty contracts, an effort level comparable to full-time effort in schools using 9-month faculty contracts. The school uses the university's definitions of ~~"full-time" and~~ 'faculty.'..." " • Spend a majority of time/effort (.50 FTE or greater based on a 12-month year) on activities associated with the School or Program, including instruction. Research and service effort should also be included in the FTE allocated to the School or Program if the research or service projects impact the School or Program and its students. The School or Program defines FTE allocations consistently and transparently and can clearly account for all time, effort and instructional or other responsibilities spent on activities outside the unit of accreditation. · Have regular responsibility for instruction in the School's or Program's public health degree programs as a component of employment. Individuals whose sole instructional responsibility is mentoring individual doctoral or research students do not meet CEPH's definition of primary instructional faculty, nor do faculty whose regular instructional responsibilities lie with non-public health degrees within the unit of accreditation, if applicable.	It is illogical that faculty operating at 1.0 FTE within nine-month contracts would count as sufficient (their FTE translates to 0.75) while institutions running 12-month contracts who have faculty members operating at less than 1.0 FTE would not count as sufficient. Since some institutional practices consider 12-month faculty who work at 0.75 – 0.80 FTE over 12 months to be full-time, a level of effort equivalent to full-time effort from a faculty member with a nine-month contract, it is reasonable to hold faculty to this same standard and to support similar university rules and definitions as the basis for counting primary instructional faculty in the ASPPH response. In addition, the proposal resolves groundless distinctions between how faculty are counted across institutions.

3	C2-B	524-564	Online Community (issue originated in the Faculty Affairs' Group)	Revise the statement so that public health programs (PHP) have the same minimal faculty requirement by range of offerings as schools (SPH) in that both should be able to count: (a) a non-primary instructional faculty , and (b) a faculty member from another concentration area as the third faculty member to the three-faculty cohort for the first degree level. ***NOTE: This proposed revision is incumbent upon retaining the important faculty threshold for schools as mandated in C2-A, line 498, "SPH employ, at a minimum, 21 primary instructional faculty."***	Not only are PHP required to have 3 primary faculty/concentration, but all 3 must uniquely count for a concentration. On the other hand, SPH must identify just 2 primary faculty, with one or both permissible as counted to another concentration. Therefore, PHP must have 3 unique primary faculty but SPH can average 1 primary faculty for every area of study. These differential faculty rules for SPH and PHP hamper PHP ability to improve quality as compared with SPH. Although CEPH has suggested that other criteria offers flexibility for PHP, it does not make sense for a PHP to have faculty members who devote 1/2 their time to one concentration and the other 1/2 to an organizational unit on the other side of campus, but who cannot devote their other time (and have it counted) towards supporting a second concentration. It is not logical for the 1/2 time a PHP faculty may devote to either concentration as considered less valuable when this effort is contained within the unit as opposed to outsourcing half their effort elsewhere.
4	C2-B	533-534	Faculty Affairs' Group	Make a clarification edit, as follows: “These individuals may ~~only~~ count ~~toward~~ among the three faculty in no more than one additional concentration.”	While some members articulated that it seems a little thin to add one faculty member for an additional degree level (lines 540-541) and that a strong program would require more resources, others thought it was an adequate bare minimum. A member noted that Section C2-C requires demonstrating a sufficient number of faculty to deliver an effective program. On a related point, CEPH has stated "The idea is that C2-A and B are the floor, and C2-C allows for more nuanced levels of peer review," thus supporting this point.
D. Curriculum					
5	D2 and D3	Gen'l	Mapping Group	While it is not a new issue, members still have concerns in assuring and monitoring that students achieve the far-ranging competencies in this round.	This concern could be addressed in CEPH's coming technical assistance sessions (draft training timeline at http://ceph.org/assets/Training_Timeline.pdf), which lists trainings planned through November 2017

6	D2	820-878	Joint MPH Group & HPM Forum & Mapping Group	Edit the MPH competencies, as follows: 1. Select epidemiologic and data collection methods appropriate for a given public health context (Level 5) 2. ~~Analyze and i~~Interpret results of quantitative and qualitative data analysis using evidence-based methods (Level 2) 3. Use computer-based programming and software to support data analysis and interpretation (Level 3) ~~4. Apply epidemiological methods to the breadth of settings and situations in public health practice~~ 4. Compare the organization, structure and function of health care and public health systems across national and international settings (Level 4) 5. Assess impacts of structural bias at organizational, community and societal levels that pose challenges to health equity (Level 5) 6. Assess population needs, assets and capacities that affect communities' health (Level 5) 7. Apply awareness of cultural values and practices to the design or implementation of public health programs (Level 3) 8. Design a population-based project, program, policy, or intervention (Level 6) 9. Explain basic principles and tools of budget and resource management (Level 2) 10. Select methods to evaluate public health programs ~~and~~ or policies (Level 5) 11. Assess multiple dimensions of the policy-making process, including ethics and evidence in relation to their capacity to improve public health and health equity (Level 5) 12. ~~Apply communications and negotiation skills to identify stakeholders and build coalitions and partnerships to influence public health outcomes~~ Propose strategies to build coalitions and partnerships for influencing public health outcomes (Level 6) 13. ~~Advocate~~ Identify advocacy strategies for programs and ~~political, social and economic~~ policies that will improve health in diverse populations (Level 1) 14. ~~Apply~~ Identify principles of effective leadership, governance and management~~, including fostering collaboration, guiding decision making, creating a vision and empowering others~~ (Level 1) CONTINUED BELOW	This list is offered as a lightly trimmed version of the proposed round 4 MPH competencies and with a few verbs made a notch or two less rigorous than the CEPH-proposed slate. It also resolves the double-barreled competencies. NOTE: The chosen verb for each proposed competency is tagged in blue, for illustrative purposes, by its level in Bloom's revised taxonomy, per the chart at http://www.aspph.org/wp-content/uploads/2014/06/CompetencyReferenceGuide1.pdf

7	D2	Cont., 820-878	Joint MPH Group & HPM Forum & Mapping Group	15. ~~Choose appropriate strategies for communicating~~ Communicate, in writing and orally, a public health issue to various audiences, including stakeholders at different levels and sectors (Level 6) ~~17. Write technical or professional papers on public health issues~~ ~~18. Deliver oral presentations on public health issues~~ 16. Perform effectively on interprofessional teams* (Level 3) 17. Apply systems thinking ~~tools~~ to a public health issue (Level 3) * "Interprofessional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes." From: Framework for Action on Interprofessional Education & Collaborative Practice (WHO/HRH/HPN/10.3)	" "
8	D2	Line 834	HPM Forum	Request for CEPH to clarify the intent of competency #5 (in row 6 above), as follows: "Assess impacts of structural bias at organizational, community and societal levels that pose challenges to health equity."	The competency is vague in its current format.
9	D2 and D3	823, 945, 947, & 951	Mapping Group	Remove four double-barreled competencies. Solve this problem by taking the verb that is the highest that most people find comfortable (as lower level behaviors are subsumed by higher order verbs). The MPH competency proposal in row 6 above resolves the MPH double-barreled issue. The following edits are recommended to remove the double-barreled DrPH competencies: • Line 947: "Create ~~and sustain~~ organizational change strategies" (as students could demonstrate, through an exercise or extracurricular activities, creation of a strategy, but not necessarily sustenance of change) • Line 951: "A~~cquire and a~~lign human, fiscal and other resources to achieve strategic goals" (again, students could demonstrate, through an exercise or extracurricular activities, alignment of resources, as compared w/the more difficult task of acquiring the resources) * Line 945: "Create ~~and implement~~ strategic plans" (same rationale as above)	One verb per competency is standard, accepted practice.

10	D3	941 & 947	Mapping Group	Two DrPH competencies present behaviors that would be impossible: (a) for most students to demonstrate during their course of study, and (b) to measure: • Line 941: “Influence behavior and policies by communicating public health science to diverse stakeholders, including individuals at all levels of health literacy” • Line 947: “Create and sustain organizational change strategies” Therefore, change the first competency as follows: "~~Influence behavior and policies by c~~Communicat~~eing~~ public health science to diverse stakeholders, including individuals at all levels of health literacy, for purposes of influencing behavior and policies" -- This 2nd competency is already changed, per row 9 above	Acquisition of the first competency requires demonstating change in behavior of individuals *other than the student him/herself* and requires there to be a sway in policies. Measuring achievement of the desired outcome, therefore, may or may not reflect student contributions to the result. Competencies need to stick to measuring ***students’*** knowledge, skills, or attitudes. --- The sustenance of change can sometime take years to document, much longer than a typical MPH students’ time in study.
11	D3	Line 907	HPM Forum	Incorporate quality and performance improvement into the DrPH competency set and revise the already-edited competency to: "Create ~~and implement~~ organizational change strategies that include quality and performance improvement."	DrPH holders should serve as major contributers to quality and performance improvement as part of their role as "transformative academic and practice leaders" (quoted statement taken from the round 4 draft criteria).
12	D5	1059-1113	Practice Section	After an in-depth conversation on whether they should stress the need to have more explicit specifications around the duration of practice, the group did not come to consensus. They report the following discussion points: 1. Some want a specified range of hours, or at least a minimum number of hours, so schools and programs have to meet explicit requirements, and 2. Others oppose listing a range of hours and, instead, ask that CEPH could include guidance related to this matter in the final CEPH Accreditation Criteria document (either in the text, glossary, or elsewhere). Explicit guidance on this point from CEPH is requested in the accompanying accreditation material.	As CEPH plans on providing technical assistance and guidance over the next several months (draft training timeline) that should help in this particular area. NOTE: While the existing criteria contains no minimum requirement for the hours in an MPH practicum, CEPH's current interpretation is that 100 hours or fewer is insufficient for a quality experience. Per CEPH, their analysis has shown that nearly all accredited schools and programs fall between 180-240 hours for their practica. The planning, supervision, and evaluation of practica is considered as well when determining compliance. Additionally, CEPH has pointed out that they are not requiring a concentrated block of time for the practicum in the proposed criteria, but rather are focused more on output/learning outcomes and whether students have acquired the stated competencies. However, schools and programs that wish to retain a traditional, "concentrated in time" practicum may continue to do so, as long as students fulfill the competencies chosen for the experience.
13	D11	1447	Joint DrPH Group	Add: “The student’s high-quality written product or dissertation is not included in this requirement.”	This statement is assumed, but is now made explicit by the proposed edit, thus removing any question of including the dissertation in the 36-semester-course-credits requirement.

Definitions					
14	Defini-tions	2433-2439	Faculty Affairs' Group	"'Concentration' refers to any area of study that the school or program advertises as available to students, via its catalog and/or website. Tracks or foci within concentrations are not considered separate "concentrations." For example, an MPH in epidemiology ~~is a concentration. An MPH in epidemiology~~ with focus areas in chronic disease and infectious disease would be ~~two~~ one concentration~~s~~, epidemiology. ~~(chronic epidemiology and infectious epidemiology). In these criteria, "concentration" is synonymous with terms such as "specialization," "emphasis area," "track" and "focus area," and, in some cases, "certificate.'"~~	The overly narrow definition of a concentration has direct implications for C2-B's minimum faculty requirements by range of offerings as it would mandate too many faculty members for overly parsed-out concentrations.