Questions & Answers and Related Comments
Listening Session/Webinar on Weds. May 4, 2016
DRAFT Accreditation Criteria, Round 3 Review
Summary Notes from Archived Video Recording [here] and PPT slides [here]

Participant Key:
DG = David Goff
LRK = Laura Rasar King
MM = Mollie Mulvanity
LW = Liz Weist

Site Visits

Q1: How will site visitors get trained for ensuring a uniform interpretation of the new criteria?
MM: We will retrain our site visitors using many of the same methods we use today. Formally retraining site visitors on new criteria is a regulation the Department of Education imposes on accreditors. We will continue a full, seven-hour day of training that includes PowerPoints, small-group and large-group discussions, case studies, and a simulated writing exercise. We will use similar methodologies going forward and will be introducing more distance-based training and deliver more updates, even when not in a period of major revision. Our goal is to maintain high standards of site visitor currency by giving more attention to training and expectations for consistent and high-quality reviews. We have been paying more attention to this issue in recent years and have seen an improvement in reviews, which we expect to increase going forward. We know that site visitors are excellent and since they are busy with full-time careers, it is the job of staff to train them properly and provide support and technical assistance, such as helpful hints, documents, and templates, to enable the site visitors to focus on doing their jobs.

LRK: Most of you on the call have worked together with CEPH staff. We are lucky enough to be one of the agencies that has staff support on every site visit. We also work internally to ensure consistency among reviews and we have appointed a staff manager who meets regularly with staff to talk about interpretation to guide the teams consistently. Consistent guidance is our goal. It is something we are absolutely focused on.

Q2. You had on the last slide “1st SV with new criteria will likely be in 2018.” What does that mean? Could you please clarify?
MM: With the caution that we do not have an implementation timeline yet, I am confident in saying that we do not anticipate actual site visit dates occurring before 2018 to comply with the forthcoming criteria. From past experience and our procedural timeline, I believe that site visits starting in, say, September of 2018 will possibly follow the revised criteria. So, if you have an accreditation term that expires on July 1, 2018, your site visit would occur in spring 2018 and it is not likely that you will be compelled to use the updated criteria. If you have an accreditation term that expires on December 31, 2018, your site visit would occur in fall 2018 and it is likely that you will follow the updated criteria. I need to emphasize this is a projection that may change.

LW: And to be clear, “SV” means “site visit”

Q3. Can we be assured that site visit teams will have at least one DrPH degree holder, preferably more, who can reflect from their experience with the degree?
MM: The answer, candidly, is “no” because of the many factors that go into selection of the site visitor pool and teams. Not every member even has an MPH; some have PhDs, some have MDs. We have to ensure firstly that site visitors are trained in the criteria and experienced in interpreting them and secondly rely on the blend of the site visit team. Some site visitors are excellent interpreters who are
helpful on a team at an institution that is very different from their own but who can provide a beautiful review. I hear the perspective of where the question is coming from, but it’s not something we will be implementing.

Implementing the New Criteria

Q4: If a MPH Program is now being revamped where this is expected to be completed by spring 2017 should we focus on the new criteria or the current criteria?

MM: This is a tricky one since we don’t have any new criteria yet. We will work one-on-one with people who fall into unusual situations. We are trying to be sensible and don’t want people to comply with obsolete criteria, but it would be irresponsible to put aside the existing criteria. We will have more information in the future. It will have to be an individual answer. Call me to talk more.

LRK: The 2011 criteria are very different from the 2016 criteria, and the 2011 criteria are not coming back, so look towards the 2016 criteria, which are vastly different. Having said that, Mollie is absolutely right, it’s an individual answer.

D1. MPH and DrPH Foundational Public Health Knowledge

Q5. I am a bit uncertain about D1 [which has to do with foundational MPH and DrPH knowledge], specifically as it relates to how a school would "validate . . . public health knowledge through appropriate methods." For example, could completion of a degree program OTHER than a "CEPH-accredited bachelor's degree in public health or MPH degree" be acceptable? Conversely, if SIMPLY completing a CEPH-accredited degree program acceptable, or is some further documentation necessary? Do each of the 14 [reference is to the 14 competencies listed in D1] need to be individually "ensured?"

MM: Those of you who have been following the three rounds to date will recall the evolution of this criterion. In our first draft we talked about skills, knowledge, and professional dispositions, giving a long list of each. These items you see know in D1 are mostly the "knowledge" items from that first list that we believe are important to validate for both MPH and DrPH graduates. In the second draft, we folded in skills and knowledge together, which resulted in a very large set. In this third iteration, we took a lot of your excellent suggestions on competencies and created a streamlined set for both the MPH and the DrPH, but when it became apparent these new sets lacked some fundamental knowledge items, we needed a way to include them that were distinct from the competencies. If you look at a number of the MPH and DrPH competencies, they are similar to other fields, such as social work, urban planning, public administration, and a master of science in nursing, in some cases. We needed a way to show what makes public health different and D1 is an attempt to do that. This is a long history lesson and now, back to the specifics of the question. CEPH came up with different ways to validate this learning, such as through an online assessment or course, independent tutorials or reading, examinations, or other tools. We also thought that since these concepts are, in many cases, embedded into undergraduate criteria, and if a student could demonstrate the knowledge, it could reduce the burden. If another program outside of public health provided the coursework that could provide the knowledge, it would be within the purview of the institution to permit acceptance. This is novel, so we look forward to your suggestions about the criterion.

LRK: Another option simply is to map them to the curricula that you offer. We understand that your students enter with a variety of experiences. Say, if you accept a DrPH student into your program with a fine arts background who lacks a public health background, you could incorporate the needed learning into your curriculum and map it. For a program that only enrolls individuals already working in public health, the answer may be different: working professionals in public health may have gotten the
knowledge through their jobs and for them it could make more sense to test out. It is meant to allow a school or program to figure out the best option for them.

**MM:** The simple part of the answer is that these items, as I’ve heard in feedback from schools and programs, are typically already well-embedded into the curricula, or would not be a challenge to incorporate, and, therefore, are almost “gimmes.”

**LW:** If you are able to access the first handout, which is the draft ASPPH recommendations, you'll see a couple recommendations on D1. One is to separate the MPH from the DrPH foundational competencies. The other is to fold D1 with the other competencies into one set. We’d really like to hear your thoughts on this issue.

**Q6.** *Section D1 has links to most of the traditional areas in Public Health (epidemiology, health policy, behavioral science, and environmental health) but does not mention biostatistical skills.*

**Is there a specific motivation for this?**

**MM:** No, and we are absolutely open to edits. We have already received some great suggestions regarding how to incorporate other concepts that may be representative of biostatistics. It was not an intentional move and we welcome more comments. It is exactly why we have this iterative process.

**Q7:** *I would support the separation of the DrPH and MPH competencies; the crossover with MPH and DrPH should be much more delineated for student and professional success.*

**MM:** I am not sure that I understand this comment, but think you are referring to D1 again. We already talked about our intentions in this criterion, and I’d be interested hearing more about your perspective. We would definitely need to see specific suggested language.

**LRK:** The competencies themselves for the MPH and DrPH degrees are already separate. I agree with Mollie and think you are referring to D1. I would suspect that many MPH programs would integrate the D1 competencies throughout their curriculum, which would meet this standard. The intent, actually, is for the DrPH to have more flexibility in the students that it enrols and gives those students many more options to gain those competencies in conjunction with their DrPH-specific competencies.

**Q8:** *CEPH appears to interpret competency as skill only - whereas a comprehensive definition of competency includes knowledge, attributes and skills - thus the ASPPH feedback to combine the two sets rather than separating out Content/Knowledge as a separate competency.*

**MM:** This comment is well-taken in that I tend to use “skill” as the short hand for knowledge, skills, and abilities, but we really need to back-up and talk about this whole framework. It’s back to D1. If we have the idea of folding these foundational competencies into the degree-specific sets, it’s going take away some of the flexibility we intended. If there are other outcomes that would be gained in sacrificing this flexibility, we could talk about those. I think to fold what we are calling foundational knowledge into the other set may have unintended consequences that we need to think through very clearly. That said, your suggestions may result in an “aha moment” that we did not consider. Again, the more specific the suggestion, the better.

**Q9.** *Beyond the mapping of the Foundational Knowledge to courses, what at the individual level of assessment must be evidenced? For example, let’s say there were 2 test questions to evidence the student’s knowledge of a particular element of the 14 item list, and the student got those questions wrong on the test--does that mean if a student does not pass a retest having had some supplemental education--that the assessment function at the individual level has not been carried out adequately?*

**MM:** That is a very rigorous and granular question and I would say our position is to allow some discretion for faculty members and administrators to make decisions about appropriate assessment. We intend our accreditation process would elicit conversations about assessment, but are not interested in prescribing such granular details.
Q10. *I think you are suggesting D1 for the MPH as an educational outcome, and as an entry expectation for the DrPH, I would expect a higher level foundational outcome for the DrPH requiring differentiation.*

**MM.** That is not the intention. Again, there seems to be some interest in exploring differentiation, so I’m going to encourage folks to give us suggested verbiage to help us understand how to alleviate the concerns about differentiation.

**LRK:** Please also keep in mind this is the minimum expectation. Any school or program could go above and beyond this expectation for either MPH or DrPH students.

**DG:** Part of the comment is absolutely true that all MPH graduates would have this foundational knowledge. Some MPH students would bring this knowledge with them into this program based on an undergraduate degree in public health, as an example. It is also clearly the case that it is an expectation that all DrPH graduates would have at least this level of fundamental knowledge. They may bring it in from having had an MPH or they may develop it during their DrPH experience. It may be that there is additional foundational knowledge expected of a DrPH graduate, which would be good reason to have a supplemental list that would apply to DrPH graduates only. If there are knowledge domains that people wish to propose for DrPH graduates, those comments would be welcomed.

### DrPH Degree

Q11: *How are schools expected to distinguish/triage students eligible for &/or advised to pursue the DrPH vs the PhD or the ScD?*

**MM:** What we have in the proposed criteria revisions is a lot more definition around the DrPH than we’ve ever had historically. While the details are still being worked out, the DrPH is going to be much more clearly defined, while the PhD is going to continue to be less specifically defined. Schools and programs will have flexibility to make PhD and ScD programs to fit their own and their student population needs, and the same will apply to DrPH programs, however, DrPH programs will have a certain degree of standardization. The decision will be very specific for each school and program that offers multiple doctoral degrees.

**LW:** I’d like to commend the DrPH Degree Framing Group, led by Dean Jim Raczynski at the University of Arkansas who is working with 16 members and partners, including practitioners, to help better define the DrPH degree in the recent rounds.

Q12: *If a DrPH applicant does not have an MPH, or has one from another school, would they be expected to take the host school’s core courses or other requirements of the host school’s MPH degree?*

**MM:** Let’s throw out the language of “core courses” for now as the current paradigm of five core courses is going away. The criteria that we have proposed represents a minimum knowledge set, as indicated in D1, that everyone with a MPH and DrPH needs to know, and for the DrPH student, an additional set of defined competencies. Individual doctoral advising that takes place in every program may identify areas where the candidate could need to acquire additional abilities. This may be due to previous degrees earned or to the student’s aptitude. The intention is not to set up a series of pre-requisite courses that must be completed before the DrPH, but to define expectations of performance and outcomes at each level. Students will get there, especially doctoral students, in consultation with faculty and advisors.

**LRK:** This takes us back to the D1 question and is a main reason why we did not break out the public health knowledge required between MPH and DrPH students. We know some DrPH programs require an MPH to have been earned and, therefore, the students will have this knowledge already. In these cases, verification by a test or an individual transcript review would work. Programs that want to accept
DrPH candidates without this background have that option. It’s a primary reason for arranging D1 the way we did. Students could gain the knowledge via coursework, readings, or in a variety of other ways.

Q13. Line 27 on the response report--how would "transformative leaders" be measured?
Leadership implies experience and a DrPH student would not have enough time to demonstrate a measurable outcome of a true transformative leadership experience.
DG: One can state a goal in describing the purpose of a degree while recognizing that it may be very difficult to prove attainment of that goal on an individual level at the time of graduation. For example, it is also true that PhD programs have a goal of developing scientists who are capable of conducting independently funded research. It is very difficult to assess the success of that goal or the program at the time of graduation with a PhD degree. It often takes at least a decade after graduation to determine whether someone is truly successful at transitioning to become an independent scientist. That does not change the goal of PhD programs of producing scientists capable of becoming independent researchers. In some ways, if you look at this text and read it as “what is the goal of DrPH education,” it is about training people who will become transformative leaders in public health practice and research and academic public health. We hope the intent is clear. The assessment of student outcomes at the time of graduation will fall short of knowing with great certainly what the graduates will be able to accomplish downstream in their professional careers to a similar extent as what we experience currently with other doctoral degrees.

Other

Q14: CEPH should state the equivalent, to clarify 42 semester credits = ?? quarter credits. Is that possible?
MM: Yes, it is 56 and CEPH will put this information into the next round of criteria.

Q15. Can you clarify more the difference between the MPH degree and the MSPH degree? I thought it was the MSPH is more research oriented and the MPH is more practice oriented. And if that is correct, is then a MPH graduate (practitioner) only able to go for a DrPH or can also go for a PhD in the future?
MM: The MSPH has different definitions and functions, depending on the institution. In some it is essentially equivalent to the MPH, but may have a different name due to historical reasons. A few accredited programs do not offer an MPH, but offer an MSPH that functions as an MPH, while others offer an MSPH that looks more like a research-oriented MS degree that is not intended to be parallel to the MPH degree. So, the MSPH cannot be generalized. Everything we have been discussing [during this webinar] in terms of D1 and the flexibility we have been talking about, including the heightened flexibility in ScD and PhD programs as compared with the DrPH, means that we do not intend to set parameters regarding what further degrees an MPH graduate would be qualified to pursue following graduation and we are avoiding saying that the MPH is required to have prior to DrPH admission. So, there is not an intended pathway required from the MPH onwards in the accreditation criteria, even though schools and programs may wish to specify such requirements.
LRK: All we require as regards admissions criteria is that you have a process to admit students. We do not require particular degrees for entrance to any program.
DG: You can let both MPH and MSPH degree holders into your PhD program. They may require different programs of study after entry based on previous exposures to course work and mentored research experiences and the prior competencies they have developed.

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Questions Answered Directly to Attendees, Post-webinar (as time had run out)

Q16: On basis of no expectation of prior MPH, should people with an MPH list that along with their DrPH degree behind their names?
A: Both ASPPH and CEPH representatives involved in the webinar agreed that it would be up to the discretion of the degree holders how they indicate their credentials.

Q17: For accredited schools that have PH and non-PH programs, will the requirement to teach PH to non-PH degrees remain? Will the requirement to include equivalent of 3 credit hours of epidemiology to non-PH PhD programs remain?
A: CEPH staff responded that yes, the requirement to ensure public health knowledge of ALL students in accredited schools remains in the draft criteria. Rather than a general idea of what “broad introduction” means, Criterion D13 gives a list of competencies and indicates that, regardless of the methods, the delivery and assessment of the knowledge should be equivalent to what would typically be associated with a three semester-credit course. The specific requirement for three hours of epidemiology is not included as such. Instead, public health degrees other than the MPH or DrPH (e.g., PhD in health policy, MS in biostatistics) “must complete coursework and other experiences, outside of the major paper or project, that substantively address scientific and analytic approaches to discovery and translation of public health knowledge in the context of a population health framework.” (Criterion D14 and D15) Again, the coursework/experiences in this area should be equivalent to a three semester-credit course. This is on top of the D13 requirements referenced above.

Q18: Want to hear more about how the field experience can be spread out throughout the program, more ideas for the culminating experience.
A: CEPH staff responded that we hope to provide more technical assistance and peer-to-peer learning opportunities after the criteria are adopted. The idea of a “portfolio approach” to assessment (Note: the language may change in the upcoming draft) for practical skills means that, if the program or school wishes, it could embed external practice opportunities in required and elective coursework. Many schools and programs already do this—for example, a program planning class may work in groups to plan projects for actual community agencies, meeting with and responding to agency staff under the supervision of the course instructor. We have seen “consulting”–style classes in disciplines such as environmental/occupational health and health management. A student would complete a sufficient number of these practice-embedded classes (the sufficient number would be decided by the school or program based on the depth and range of the assignments) and demonstrate attainment of the requisite competencies by pulling together the practice-based work that she completed during these classes. We expect to see innovation in this area—and we also expect that many schools and programs will choose to maintain some version of the currently prevalent internship/practicum model. The decision will be based on the school/program’s specific mission and setting and its student population.