SOCIETY FOR PUBLIC HEALTH EDUCATION

Global Leadership for Health Education & Health Promotion

26 February 2013

Jerilyn Glass, MD, PhD
Designated Federal Official, ACTPCMD
Health Resources & Services Administration
5600 Fishers Lane, Room 9A-27
Rockville, Maryland 20857

RE: Comments on Draft ACTPCMD Tenth Report

Dear Dr. Glass:

Thank you for inviting the Society of Public Health Education (SOPHE) to offer comments on the draft report on *Interprofessional Education (IPE), by the* Advisory Committee on Training in Primary Care Medicine and Dentistry.

The Society for Public Health Education (SOPHE) is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. Members include behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion in both the public and private sectors. Collectively, SOPHE's 4,000 national and chapter members work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

Overall, SOPHE is in general agreement with the IPE draft report and believes it makes important recommendations concerning the multilevel approach necessary to ensure the successful training of primary care professionals. SOPHE leaders who are involved with educating multiple disciplines have provided these comments and suggestions for your consideration:

1. To help provide clarity of intent at the onset, we suggest starting the document with a Purpose and Rationale for the proposed IPE, rather than the Vision and Introduction.

2. It will be helpful if one or two scenarios are provided in the document to help illustrate how the patient-centered and team-based care actually becomes operational.

3. A pilot project demonstrating the feasibility and efficacy may be warranted before recommending full implementation of IPE. If there is a reference for a demonstration project please highlight for clarity, especially one demonstrating the delicate collaborative leadership displaying an IPE environment fostering evidence of interprofessional development outcomes.

4. Recommend expanding the rationale for Congress to restore and enhance funding for Section 747 at $560 million for next fiscal year. Please provide clarity how this recommendation relates to IPE and the potential return on investment that policymakers are anticipating in this austere fiscal climate.

5. Much of the language in this document focuses on clinical/patient care and could be expanded to reflect the importance and necessity of engaging/melding community agencies and services, e.g., ACS, ALS, MS Society, etc. transcending the academic and professional settings. Regarding Page 1 description of team, see recommended text edits in italics below:

   Traditional clinical professionals (advanced-practice nurses, behavioral and mental health professionals, care coordinators and mangers, dental hygienists, dentists, health educators, medical assistants, nurses, pharmacists, physician assistants, physicians, *and social workers*);
   Patient service personnel (clinical and laboratory technicians, operators, *lay health workers e.g. promotoras, community health workers,* and receptionists);
   Population-health *and community health* professionals (addressing fields such as patient safety, *performance/quality improvement,* public health and *prevention, health literacy and communication, community health assessments, program planning and evaluation, health behavioral research, cultural awareness and competency)*; and

6. Instruction of specific content (pg. 4) should strongly recommend and encourage the use of quality online methodologies for training and sharing information, in multiple languages. This method would assist many people in rural and tribal areas to obtain the necessary information. Health education specialists and other professionals with experience in online education should be referenced to assist with this component.

7. Expand Instructions about IPE (pg. 4.) to include the revision of the philosophical foundations of each discipline to integrate IPE.

8. On pages 4-8, increase emphasis on the priority of the community member and patient as a central team member. Expand the instruction of specific content and role development to prospective and current patients as central members of a care team (e.g., community education, clinic and pre-surgery clinics) who can assist in sustaining behavior change and (training grant education programs (pg. 8, #4). Suggested text edits are provided in *italics* below:

   Title VII training grant education programs should employ models of team-based care, in a variety of settings, that advance learners' mastery of the following areas:
   - Care for vulnerable populations (a priority area);
   - Health literacy, *broadly defined including such components as readability, numeracy, wayfaring, signage, and patient/provider communication,* and patient education (a priority area);
   - *The patient as a central member of the interprofessional team; *greater emphasis on the priority of this area for learners' and stakeholders (community members as patients)*
   - Population health and prevention *within a community and cultural context;*
   - Patient behavioral change and self-management of the patient's own health *with consideration of the patient's cultural norms;*

9. Consider supporting grants to leading accreditation and credentialing bodies e.g., Council on Education for Public Health (CEPH), The National Commission on Health Education Credentialing (NCHEC), to assist them as they 1) modify their accreditation and/or credentialing criteria to include an IPE component and 2) support the agencies to partner with educational institutions to modify and enhance curricula to best obtain the desired outcomes.

10. Regarding recommendation 5 (pg. 7), need to recognize the different technology capabilities (or lack therof) in some rural/frontier/tribal communities and provide information in a wide array of mediums.

11. Regarding recommendation 4 (page 8), expand to include a requirement in Title VII grants that applicants must demonstrate how they involve IPE and their evaluation/reporting mechanisms to hold them accountable for patient involvement.

12. Regarding recommendation 3 (pg. 10), expand to include organizational development strategies and the need for systems changes within health care settings to support the practice of IPE.

13. Consider referencing the following article published in the Journal of Evaluation in Clinical Practice "Adaptive leadership and the practice of medicine: a complexity-based approach to reframing the doctor-patient relationship." 2010. http://www.ncbi.nlm.nih.gov/pubmed/20846289 This article defines the distinction between adaptive vs technical work- putting the patient on medication or ordering lab tests is technical. "Adaptive challenges differ from technical challenges. Recognizing the problem, and figuring out how to solve it, both require learning by the stakeholders (e.g. patients), etc.

Thank you for your kind consideration. Please contact us if we can provide any additional information. SOPHE looks forward to receiving the IPE final report and discussing opportunities for our future involvement to support the goals and recommendations of this report.

Sincerely,

Elaine Auld, MPH, MCHES
Chief Executive Officer