



American Association of Public Health Physicians

3433 Kirchoff Road

Rolling Meadows, IL 60008-1842

Phone (847) 371-1502; Fax (847) 255-0559

Web Site: <http://www.aaphp.org> E-mail: aaphp@reachone.com

The voice of public health physicians, guardians of the public's health

Preventive Services ToolKit Project

Instructor's Manual

Module 1-- Intro

October 7, 2006

Prepared by Joel L. Nitzkin, MD, MPH; **PSTK** Principal Investigator and Project Director

504 899 7893; jln-md@mindspring.com

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Slide 1 – Title

Preventive Services ToolKit Seminar/Workshop

(Title and Host)

September 29, 2006
Marvin Center, GWU
Washington, DC
Presented by AAPHP

Today's workshop will introduce participants to a number of public health, preventive medicine, and public administration skills that we (the American Association of Public Health Physicians) believe to be of substantial value in advocating, implementing, and expanding preventive services in and through healthcare entities.

Some of the material will be familiar to many of you. Other elements will be entirely new. Since the focus is on skill-building rather than didactic training, the seminar/workshop

time will consist of about equal portions of lecture and interactive workshop. This, in turn, will be supplemented with post-workshop consultation for those wishing to apply these skills in real-life healthcare settings.

Slide 2: AAPHP Team

AAPHP
Preventive Services Toolkit

Prepared by the AAPHP Team
 Joel L. Nitzkin – Principal Investigator
 Christopher M. Buttery
 Dave Cundiff
 Patricia Falcao
 Hugh S. Fulmer
 Robert G. Harmon
 Kevin Sherin
 Jonathan B. Weisbuch

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Note: If there are less than about 30 participants – this would be a good time for both the faculty and each participant to introduce them to the group – as an ‘icebreaker.’ After the introductions, I (JLN) will generally encourage participants to ask questions at any time, and break into the slide show any time I say anything that they question, doubt or don’t fully understand.

The materials you will see today have been pulled together and developed by the AAPHP PSTK team – a group of seasoned current or ex- local state and local health directors who have found the skills in this workshop to be both of substantial practical value, but not referenced in the current professional literature and very inconsistently included in MPH, Preventive Medicine residency and other training programs.

While this skill set has been pulled together by a group of physicians – the training in question is intended for all public health and healthcare professionals, and community advocates who would like to enhance their ability to enhance the delivery of preventive services in both community and clinical settings.

Slide 3: PSTK Project

Preventive Services Toolkit Project

- An AAPHP Project
- Funded by CDC
 - National Center for Health Marketing
 - Division of Partnership Communications
- 3-Year Cooperative Agreement
 - Initiated September 2005

9/29/06 AAPHP PSTK Intro Module 1, Slide 3

The American Association of Public Health Physicians (AAPHP) was founded in 1954 to be the voice of public health physicians, guardians of the public’s health. Originally it consisted almost entirely of state and local directors of health departments. In subsequent years this mission and AAPHP’s impact on health policy at the national level through AMA, APHA, and various federal agencies attracted members from federal service, academia, private practice and other settings.

Over the years, this self-described community of public health physicians has accumulated a substantial amount of practical experience in terms of what does and does not work to design and implement both clinical and community preventive services and to partner with other public health professionals, healthcare providers and community groups to leverage substantial improvements in community health status far in excess of their meager agency budgets. The material in today’s workshop largely represents a distillation of lessons learned by AAPHP leadership and brought up to date to address our current health concerns and working environments. Because of the nature of these skills and tricks of the trade, many are not yet currently taught in MPH and other public health and preventive medicine training programs, and most have not had the benefit of publication in peer-reviewed journals. The goals of this project, in addition to improvement of the health status of communities represented in these workshops, include laying the groundwork for some or all of this material to be incorporated into educational programming for both public health and healthcare professionals, and even lay the groundwork needed to establish the desired evidence base for these skills.

If you can forgive me for inserting a commercial word for our sponsor, we do have information available for those who may be interested in learning more about AAPHP.

The **CDC program funding this project** is the one previously known as the Public Health Program Office (PHPO). While originally focused primarily on state and local public health agencies, this renamed division has now broadened its focus to include non-traditional partners, including the whole spectrum of the healthcare delivery system. Their interest in expanding preventive programming, quality assurance and preparedness capabilities in both public and private sectors and the skills we are teaching today represent a perfect match and thus, their provision of the financial support that makes these workshops possible.

Slide 4: PSTK Modules

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Note: the narrative on this slide should generally be limited to the modules to be presented to this audience

1. This **Introductory** module will set the stage for the other seven educational modules. It will focus on common misconceptions in public health and healthcare settings, and the differing mindsets of the various players in each of those settings. *Nine modules have been developed by the PSTK project – eight educational, and one (the wrap-up), administrative in nature. of these modules will be presented in today's seminar/workshop.*
2. The **Evidence** module discusses evidence base for community and clinical preventive services, implementation guidelines, and benchmarks – and how to use them when planning to advocate for new or expanded services. This module, as well as several others, is formatted for retention by participants as resource materials.
3. The **Planning** module addresses how to efficiently decide what problems to address and how to structure a package of interventions that will best address these problems in your community or patient population. This module also addresses the coding of preventive services in healthcare settings, software and statistical management of the data.
4. The **Data** module provides “tricks of the trade” in designing and conducting small surveys and group interview sessions to help plan advocacy strategy, plus how to gather these data without running afoul of HIPAA regulations.
5. The **Epidemiology as a Policy Tool** module is a primer on how to introduce public health and medical science into policy and political deliberations to dramatically improve the odds that the programming implemented will actually secure the desired health-outcome and cost-related benefits.
6. The **Power Structure Analysis** module is at the very heart of our PSTK project – and our most sought-after module. It is a rapid and user-friendly protocol for stakeholder analysis for the purpose of better enabling workshop participants to get their respective bureaucracies and legislative bodies to do what they want them to do.
7. The **Cost-related** module is designed to improve communications and understanding between health professionals, on one side, and policy makers and administrators, on the other side, who tend to see all issues and problems in dollar terms. This module focuses on Return on Investment concepts as they are currently used in managed care settings.
8. The **Partnering** module presents Principles of Community Oriented Primary Care (COPC) as adapted by the PSTK team for use in specialized medical services. It provides an efficient and effective protocol for partnering between healthcare, public health, community and private-sector entities. It is largely structured around a scenario in which a pulmonologist in an academic department of pediatrics would like to help create a community-based intervention to

prevalence and severity of asthma in an inner-city population by reducing exposure to mold and cockroach antigen in the home.

- 9. The **Wrap-up** module is for evaluation of this seminar-workshop, and to set the stage for post-workshop follow-up and consultation. It will include a brief (and anonymous) multiple-choice quiz on the modules covered today.

Slide 5: Goals, Content and Methods

Goals, Content and Methods

- Goal:
 - o Impart new and enhanced skills
- Content:
 - o Assessment
 - Frames, Mindsets, and Data Models
 - o Policy development and implementation
 - “tricks of the trade,” guidelines and protocols
- Methods:
 - o Seminar/workshop
 - o Post-workshop consultation

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As stated before, the **Goal** of this seminar-workshop is to impart and enhance skills that will enable participants to more effectively advocate for, implement and maintain both community-based and clinical preventive services.

There are two major components to the **content** are a set of assessment tools dealing with frames, mindsets and data modules and a group of skill sets, or “tricks of the trade” for application and use of these assessment tools.

The **PSTK Methods** consist of lecture presentation, audience interaction and post-workshop follow-up and consultation.

Slide 6: Frames, Mindsets, Data Models

Frames, Mindsets, Data Models

- Frame = perspective; point of view
- Mindset = the way people think in organizational settings
- Data Models
 - o Medical, Public Health and Community

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A “**Frame**” is a perspective, or point of view. Imagine yourself with an empty picture frame in your hands, and the proverbial elephant standing next to you. If you look close at the leg – it looks like a tree. If you look close at the trunk, it looks like a snake, If you get real close and look at the side, you can see the texture of the skin. If you step way back, you can see the entire elephant. There is no “right” or “wrong” frame. Each frame gives you information you didn’t have before, and, as you consider a new problem or opportunity, you never know in advance which bits of information will be most critical to the

decisions you have to make. It therefore is a good practice to spend a few minutes from every potentially important perspective.

When considering health-related issues and problems, there are two major sets of perspectives – one we call “mindsets,” the other, “data models.”

The term “**mindsets**” deals with the way different people think in health-related settings. We’ll get to those in a minute.

The term “**data models**” refers to how healthcare, public health and community people, respectively, tend to think about health-related issues and problems.

Slide 7: Mindsets

Mindsets

- (PSA Module)
- Personal
- Technical
- Administrative
- Policy/Political
- Organizational Culture
- (adapted from Graham Allison, *Essence of Decision*)

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The **Mindsets** will be addressed in greater detail in the Power Structure Analysis model. We are introducing them here

because they are important in framing our approach to each of the other modules.

“Personal” refers to your personal value orientation and character type – who you are, as a person, and how you might want to approach a specific health issue. For example, if you are a neurosurgeon, you might not much care about the issue of contraception for sexually active teenage girls. If however, you are a primary care physician in a community clinic, or a clergyman, you might have passionate views on this topic.

“Technical” refers to what we learned in school – the scientifically correct ways to diagnose and manage health-related problems.

“Administrative” thinking has to do with rules, regulations, and standard operating procedures. Budget and personnel people and program supervisors tend to think in these terms. For example, if you are running a screening clinic that you think could best and most cost-efficiently run by a nurse practitioner, but you are in an organization that has no job classification for a nurse practitioner – you will either have to run it with a doctor or RN or take the steps needed to create a new job classification (which may take six months or more). In other words, whenever what technically makes sense conflicts with a rule or standard operating procedure, the rule will prevail until and if you can get it changed.

“Policy/Political” thinking deals with values and perceptions. It asks who gets the benefit, who pays the cost, and is the proposed new program consistent with what our organization is here to do. It deals with conflict and negotiation between special interest groups of unequal power. What is scientifically or technically correct has nothing to do with how they think or how they act unless they can be convinced that the science really matters. At the national level, we see this in issues having to do with tobacco control and global warming. At a hospital or clinic level you might see it when asking for funds to hire a health educator to council fat kids and their parents about loosing weight. If the CEO or Board see this as a social, not medical service – you loose.

If the human resources administrator, in the example above, is not willing to create the nurse practitioner job classification you want, your only recourse might be to appeal this to the CEO. In doing so, you might get your nurse practitioner classification, but, in the process, you might loose your job or piss-off the human resources administrator, who will then be unwilling to work with you on other issues.

“Organizational Culture” is the term that refers to the unwritten rules that guide the behavior of the people within the organization. In some organizations, this stifles ambition and creativity. In others, it means boosting the ego of an incompetent boss – or deciding to seek employment elsewhere. In many health-related organizations (clinics, hospitals, academic centers, health departments, etc) – the organization is highly dysfunctional – and, if what makes sense to the mission of the organization and the population it serves conflicts with the prevailing organizational culture – like bringing proper attention to an incompetent or abusive colleague – the organizational culture prevails – and the organization and its clients suffer the consequences.

This Mindset Model is based on the work of Graham Allison, and his 1971 (Little, Brown) paperback book entitled “Essence of Decision: Explaining the Cuban Missile Crisis.” For 13 days in October of 1963, the world stood at the brink of all-out nuclear war, as Russians were placing nuclear missiles on the island of Cuba. Then-president John Kennedy called together all his top advisors for guidance on how best to proceed. The advice he got was so conflicted that, in the end, he, alone, had to make the final decision. Years later, Allison interviewed those who advised the President, and developed the model we have just presented. It is a very strange twist on the theme of “where you stand depends on

where you sit.” The book itself makes for an interesting read, with one chapter describing what is going on with the missile crisis, and the next analyzing the decision process.

Slide 8: Data Modules

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The data models are much simpler. They will be addressed in more detail in the Epi and Partnering modules.

Slide 9: The

The medical people tend to think in terms of diagnosis and medical procedure.

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Slide 10: The

The public health people tend to think in terms of risk factor, and in terms of demographics, vital records, and other population-based data sets.

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Slide 11: The

The community people tend to think in terms of social justice, economic status, and determinants of behavior and

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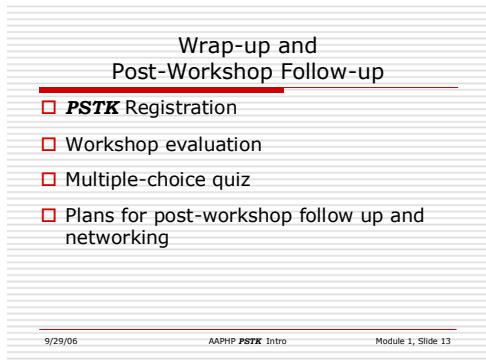
Slide 12: The

that organizational culture in most settings suggests that the answers are “True,” while a technically correct answer that would support

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Slide 13: Wrap-up and

Note: The final 3 slides in the Intro Module are intened as a transition to the rest of the agenda, and to alert participants as to the plans for the wrap-up module. The “Q & A” slide at the end of each



Note: picture of slide 14 “Q and A” not included in this instructor’s manual.