Tougher than Rocket Science, or Just Messier? Using Research to Improve U.S. Public Health Delivery

Glen P. Mays
University of Kentucky, glen.mays@uky.edu

Click here to let us know how access to this document benefits you.

Follow this and additional works at: https://uknowledge.uky.edu/hsm_present

Part of the Health and Medical Administration Commons, Health Economics Commons, Health Policy Commons, and the Health Services Research Commons

Repository Citation
https://uknowledge.uky.edu/hsm_present/76

This Presentation is brought to you for free and open access by the Health Management and Policy at UKnowledge. It has been accepted for inclusion in Health Management and Policy Presentations by an authorized administrator of UKnowledge. For more information, please contact UKnowledge@lsv.uky.edu.
Tougher than Rocket Science, or Just Messier?

Using Research to Improve U.S. Public Health Delivery

Glen Mays, PhD, MPH
University of Kentucky

glen.mays@uky.edu

University of Victoria | Renewing Public Health Systems & Services | 9 October 2014
Overview

Why study public health systems?

Examples of systems research in public health
  - Delivery system organization & structure
  - Finance and economics

Resources for advancing the field
Vicious cycles to learning systems

Limited public understanding & political support

Incoherence in missions, Complex, fragmented, variable responsibilities & expectations financing & delivery systems

Large inequities in resources & capabilities Variable productivity and efficiency

Resources incongruent with preventable disease burden

Gaps in reach & implementation of efficacious strategies

Difficulties demonstrating impact, value & ROI

Translate evidence for policy and administrative decisions & advocacy

Discover causes & consequences of variation in public health delivery
Failures in population health

Figure 1. There are large differences in life expectancy and health care spending across OECD countries 2008.

1. Or latest year available.
Source: OECD Health Data 2010.
Failures in population health

Premature Deaths per 100,000 Residents

Commonwealth Fund 2012
Drivers of population health failures

Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%

Drivers of population health failures

>75% of US health spending is attributable to conditions that are largely preventable
  – Cardiovascular disease
  – Diabetes
  – Lung diseases
  – Cancer
  – Injuries
  – Vaccine-preventable diseases and sexually transmitted infections

<5% of US health spending is allocated to prevention and public health

CDC 2008 and CMS 2011
Missed opportunities in public health delivery

Evidence-based public health strategies reach less than two-thirds of U.S. populations at risk:

- Smoking cessation
- Influenza vaccination
- Hypertension control
- Nutrition & physical activity programs
- HIV prevention
- Family planning
- Substance abuse prevention
- Interpersonal violence prevention
- Maternal and infant home visiting for high-risk populations
A field of inquiry examining the organization, financing, and delivery of public health services at local, state and national levels, and the impact of these activities on population health.

Strategies to promote health and prevent disease & injury on a population-wide basis: programs, policies, administrative practices.

Mays, Halverson, and Scutchfield. 2003
**PHSSR’s place in the continuum**

**Intervention Research**
- What works – proof of efficacy
- Controlled trials
- *Guide to Community Preventive Services*

**Services/Systems Research**
- How to organize, implement and sustain in the real-world
  - Reach
  - Enforcement/Compliance
  - Quality/Effectiveness
  - Cost/Efficiency
  - Equity/Disparities
- Impact on population health
- Comparative effectiveness & efficiency
Striving for authenticity in practice-based research

- Research that tests effectiveness & impact of public health practices in real-world *public health settings*

- Research designed to address uncertainties and information needs of real-world public health *decision-makers*

- Research that evaluates the implementation and impact of *innovations in practice*

- Research that uses *observations generated through public health practice* to produce new knowledge
Complexity in public health delivery systems

Health & Social Systems
- Resources & expertise
- Participation incentives
- Scale of operations
- Compatibility of missions
- Division of responsibility

Public Health Agencies
- Legal authority
- Governing structure
- Leadership
- Funding levels & mix
- Staffing levels & mix
- Intergovernmental relationships

Needs
- Preferences
- Risks
- Threats
- Resources
- Perceptions

Population & Environment
- Distribution of effort
- Nature & intensity of relationships

Strategic Interactions
- Decision Support
  - Accreditation
  - Performance measures
  - Practice guidelines
  - Quality improvement

Outputs and Outcomes
- Reach
- Effectiveness
- Timeliness
- Adherence to EBPs
- Efficiency
- Equity

Mays et al 2009
A Key PHSSR Goal: Optimization

How to optimally deploy a diverse collection of responsibilities, resources, actors & expectations?

- Epidemiologic **surveillance & investigation**
- Community health **assessment & planning**
- Communicable disease control
- Chronic disease and injury prevention
- Health education and communication
- Environmental health **monitoring and assessment**
- Enforcement of health **laws and regulations**
- Inspection and licensing
- **Inform, advise, and assist** school-based, worksite-based, and community-based health programming

...and roles in **assuring access** to medical care
Standardization vs. Customization in public health delivery

**Standardization**

- Harmful variation
- Wasteful variation
- Inequitable variation
- Race to the bottom
- Network externalities: interoperability/coordination

**Customization**

- Target resources to greatest needs/risks
- Tailor approaches to values & preferences of stakeholders
- Deploy unique resources & skills to their best purposes

Effectiveness
Efficiency
Equity
Diffusion of Public Health PBRNs

- First cohort (December 2008 start-up)
- Second cohort (January 2010 start-up)
- Affiliate/Emerging PBRNs (2011-14)
PBRNs as Mechanisms for Learning

Translation & application

Identify Common questions of interest

Engaged practice settings

Research partner

Apply Rigorous research methods

Analysis & interpretation

Data exchange
Pathways for research and learning about public health value

- Measuring practice & performance
- Detecting variation in practice
- Examining determinants of variation
  - Organization
  - Financing
  - Workforce
- Determining consequences of variation
  - Health outcomes
  - Economic outcomes
- Testing strategies to reduce harmful, wasteful, & inequitable variation in practice and outcomes
PBRN Research Progression

Delivery System Organization and Structure

Practice Variation

Volume, Intensity, and Quality of Delivery

Cost of Delivery

Value of Delivery
A PBRN Timeline

- **2008**: Launch
- **2009**: First cohort of PBRNs start
- **2010**: Second cohort of PBRNs start, RIAs
- **2011**: Quick Strikes, Affiliate networks start
- **2012**: RACE Awards
- **2013**: MPROVE Awards, DIRECTIVE Awards Announced, DACS Awards start
- **2014**: Affiliates network start

Launched in 2008, the first cohort of PBRNs started in 2009, followed by the second cohort in 2010. RNAs were initiated in 2011, Quick Strikes began in 2012, and MPROVE Awards were announced in 2013. DIRECTIVE Awards started in 2014.
PBRN Reach

- **1593** local public health agencies
- **35** state agencies
- **52** academic research units
- **58** professional & community organizations
Productivity & Dissemination

- 60 competitively awarded research projects
- 68 articles in peer-reviewed journals
- 221 presentations and conferences & meetings
- 51 reports & tools in the grey literature
- >15,000 downloads of *Frontiers in PHSSR* articles
- >8,000 downloads from Research Archive
- >2,000 page views on PublicHealthEconomics blog
National Coordinating Center

- Intramural research activities
  - **Public Health Value**: Cost estimation & economic evaluation
  - **Public Health Reform**: Effects of ACA on public health delivery

- Extramural research programs
  - Quick Strike studies
  - Natural Experiments in Public Health Delivery
  - Predoctoral and Postdoctoral Awards
  - Mentored Research Scientist Awards
National Coordinating Center

- Data Development
  - Periodic census surveys of local and state agencies
  - National Longitudinal Survey of Public Health Systems
  - Public Health Activities and Services Tracking (PHAST): compiling existing administrative data across states

- Dissemination & Translation
  - Weekly Work in Progress Webinars
  - Open-access journal: *Frontiers in PHSSR*
  - Newsletters, Podcasts, Blogs
  - Briefings with policy stakeholders
Ongoing research: organization and structure

- Who contributes to public health delivery?
- How are roles and responsibilities divided?
- How and why do delivery systems vary and change over time?
- How do system structures affect public health delivery and outcomes?
Delivery of recommended public health activities

Variation in Scope of Public Health Delivery

Delivery of recommended public health activities, 2012

Inter-organizational relationships in public health delivery systems
Organizations contributing to local public health production

<table>
<thead>
<tr>
<th>% Change 2006-2012</th>
<th>Scope of Production 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>-50%</td>
<td>10%</td>
</tr>
<tr>
<td>-30%</td>
<td>30%</td>
</tr>
<tr>
<td>-10%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Local health agency
Other local government
State health agency
Other state government
Hospitals
Physician practices
Community health centers
Health insurers
Employers/business
Schools
CBOs

Estimated crowd-out in hospital contributions to public health activities

Note: GLLAMM estimates, holding all other variables constant in the model
A typology of public health delivery systems

<table>
<thead>
<tr>
<th>Scope</th>
<th>Centralization</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Mod</td>
<td>High</td>
</tr>
<tr>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Mod</td>
<td>High</td>
<td>Mod</td>
</tr>
<tr>
<td>Mod</td>
<td>Low</td>
<td>Mod</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
<td>Mod</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
<td>Mod</td>
</tr>
</tbody>
</table>

Source: Mays et al. 2010; 2012
Population health and delivery system change

Percent Changes in Preventable Mortality Rates Attributable to Delivery System Type

- Infant Deaths/1000 Live Births
  - Cluster 3
  - Clusters 4-5
  - Cluster 6
  - Cluster 7

- Cancer deaths/100,000 population
  - Comprehens
  - Conventional
  - Limited
  - Very Limited

- Heart Disease Deaths/100,000
  - Comprehens
  - Conventional
  - Limited
  - Very Limited

- Influenza Deaths/100,000
  - Comprehens
  - Conventional
  - Limited
  - Very Limited

- Infectious Disease Deaths/100,000
  - Comprehens
  - Conventional
  - Limited
  - Very Limited

Fixed-effects models control for population size, density, age composition, poverty status, racial composition, and physician supply.
Ongoing research: financing, costs and economics

- How does public health spending vary across communities and change over time?
- What are the health effects attributable to changes in public health spending?
- What are the medical cost effects attributable to changes in public health spending?
- What are the opportunities for improving efficiency in public health delivery?
Mortality reductions attributable to local public health spending, 1993-2008

Infant mortality  Heart disease  Diabetes  Cancer  Influenza  All-cause  Alzheimers

Hierarchical regression estimates with instrumental variables to correct for selection and unmeasured confounding

Mays et al. 2011
Medical cost offsets attributable to investments in public health delivery, 1993-2008

For every $10 of public health spending, \(\approx$9 are recovered in lower medical care spending over 15 years

### Estimated value of public health spending

- **10% increase in public health spending in average community:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health cost</td>
<td>$594,291</td>
</tr>
<tr>
<td>Medical cost offset</td>
<td>-$515,114 (Medicare only)</td>
</tr>
<tr>
<td>LY gained</td>
<td>148</td>
</tr>
<tr>
<td>Net cost/LY</td>
<td>$534</td>
</tr>
</tbody>
</table>
Economies of scale and scope in public health delivery systems

Source: 2010 NACCHO National Profile of Local Health Departments Survey
Economies of scale and scope in public health delivery

Mays et al. 2013
Gains from regionalizing public health delivery

Mays et al. 2013
Measures of Interest

- **Availability/Scope**: specific activities produced
- **Volume/Intensity**: Frequency of producing activity over period of time
- **Capacity**: Labor and capital inputs assigned to an activity
- **Reach**: Proportion of target population reached by activity
- **Quality**: Effectiveness, timeliness, equity of activity
- **Efficiency**: Resources required to produce given volume of activity
MPROVE Example: Implementation of community-wide health education campaigns to promote physical activity
MPROVE Example: Implementation of educational interventions to reduce tobacco use and/or exposure
MPROVE Example: timeliness of enteric disease investigations

State public health research network

Completion time (days)

Multi-network Practice and Outcome Variation Examination Study (MPROVE) 2014
## Local Health Departments Engaged in Research Implementation & Translation Activities During Past 12 months

<table>
<thead>
<tr>
<th>Activity</th>
<th>PBRN Agencies</th>
<th>National Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent/Mean</td>
<td>Percent/Mean</td>
</tr>
<tr>
<td>Identifying research topics</td>
<td>94.1%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Planning/designing studies</td>
<td>81.6%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Recruitment, data collection &amp; analysis</td>
<td>79.6%</td>
<td>50.3%</td>
</tr>
<tr>
<td>Disseminating study results</td>
<td>84.5%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Applying findings in own organization</td>
<td>87.4%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Helping others apply findings</td>
<td>76.5%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Research implementation composite</td>
<td>84.04 (27.38)</td>
<td>30.20 (31.38)</td>
</tr>
<tr>
<td>N</td>
<td>209</td>
<td>505</td>
</tr>
</tbody>
</table>
Conclusions: getting inside the box

- Engagement of practice and research partners
- Sensitive and specific measures
- Research designs in real-world settings
- What works best in which settings and why
- Informed public health decisions
- Smarter investments and greater value
Toward a “rapid-learning system” in public health

In a learning health care system, research influences practice and practice influences research.

Evaluate
Collect data and analyze results to show what does and does not work

Implement
Apply the plan in pilot and control settings

Design
Design care and evaluation based on evidence generated here and elsewhere

Adjust
Use evidence to influence continual improvement

Disseminate
Share results to improve care for everyone

Internal and External Scan
Identify problems and potentially innovative solutions

For More Information

Supported by The Robert Wood Johnson Foundation

Glen P. Mays, Ph.D., M.P.H.

Email: publichealthPBRN@uky.edu
Web: www.publichealthsystems.org
Journal: www.FrontiersinPHSSR.org
Archive: works.bepress.com/glen_mays
Blog: publichealtheconomics.org