Accreditation and Standardization in Public Health

Glen Mays, University of Kentucky
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Glen Mays, PhD, MPH
University of Kentucky

glen.mays@uky.edu

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Unfortunate variation in health system performance

Source: Commonwealth Fund 2012
>75% of national 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 national health spending is allocated to public health and prevention

CDC 2008 and CMS 2011
Vicious cycles in public health delivery

Limited public understanding & political support

Incoherence in missions, responsibilities & expectations

Complex, fragmented, variable 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
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
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
Complexity in public health delivery

Public Health System
- Public Health Agency
  - Legal authority
  - Governing structure
  - Leadership
  - Funding levels & mix
  - Intergovernmental relationships

Public Health
- Legal authority
- Funding levels & mix
- Intergovernmental relationships
- Leadership

System
- Scope of services
- Staffing levels & mix
- Distribution of effort
- Nature & intensity of relationships

Resources & expertise
- Participation incentives
- Distribution of effort
- Nature & intensity of relationships

Needs
- Perceptions
- Preferences
- Risks
- Threats
- Resources

Population & Environment
- Needs
- Preferences
- Risks
- Threats
- Resources
- Perceptions

Strategic Decisions

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

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

Mays et al 2009
Our fundamental challenge

- Distinguishing **desirable** variation from **unwarranted** variation in public health delivery
  - Harmful: under-use
  - Wasteful: over-use, mis-use
  - Inequitable: haves and have-nots

- Reducing **unwarranted** variation while promoting **desirable** variation
  - Flexibility
  - Targeting
  - Tailoring
Local Variation in Public Health Investments

Gini = 0.485
Changes in Local Public Health Spending 1993-2010

62% growth

38% decline
Variation in public health practice

Mixed Results In Tracking Food Scares

Minnesota health officials investigate all reports of food-borne illness, but officials in many states do not. From 1990 to 2006, Minnesota reported 548 outbreaks, while Kentucky reported 18.

Reported outbreaks of food-related illness
Per 100,000 people, 1990 to 2006

Source: Centers for Disease Control and Prevention
Under-use of evidence-based practices

Missed Opportunities
Local Health Departments as Providers of Obesity Prevention Programs for Adolescents
Sandy J. Slater, PhD, Lisa M. Powell, PhD, Frank J. Chaloupka, PhD

Percent of local health departments offering evidence-based obesity programs

Slater et al. 2007

Healthy eating programs
Physical activity programs
Obesity control programs
Variation and Change in Public Health Delivery

Delivery of recommended public health activities

Variation and Change in Public Health Delivery

Delivery of recommended public health activities, 2012

Organizations engaged in local public health delivery

% Change 2006-2012

-50%  -30%  -10%  10%  30%  50%

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

Scope of Delivery 2012

Seven types of public health delivery systems

Source: Mays et al. 2010; 2012
Changes in health associated with delivery system

Percent Changes in Preventable Mortality Rates by System Typology

- Infant Deaths/1000 Births
- Cancer deaths/100,000 population
- Heart Disease Deaths/100,000
- Influenza Deaths/100,000
- Infectious Disease Deaths/100,000

Fixed-effects models control for population size, density, age composition, poverty status, racial composition, and physician supply.
Mortality reductions attributable to local public health spending, 1993-2008

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

Mays et al. 2011
Medical cost offsets attributable to local public health spending, 1993-2008

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

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
Scope and Timing of H1N1 Response Activities: by Agency Accreditation Status

Standardization AND Customization

2012 Institute of Medicine Recommendations

- Identify the components and costs of a minimum package of public health services
  - Foundational capabilities
  - Basic programs
- Allow greater flexibility in how states and localities use federal public health funds
- Implement a national chart of accounts for tracking spending levels and flow of funds
- Expand research on costs and effects of public health delivery
  - What works best, for whom, in what contexts?

Next generation public health delivery

Public health agency as chief health strategist to find the right mix of standardization and customization

- Articulate population health needs & priorities
- Engage community stakeholders
- Plan with clear roles & responsibilities
- Recruit & leverage resources
- Develop and enforce policies
- Ensure coordination
- Promote evidence-based practices
- Monitor and feed back results
- Mobilize performance improvement
- Ensure transparency & accountability: resources, results, ROI
Why change now?

Next Generation Public Health Delivery

- Hospital community benefit regs
- Funding constraints
- Accountable care organizations
- Patient centered medical homes
- Employer wellness incentives
- Health insurance expansions
- Health information exchange
- Accreditation
Toward a “rapid-learning system” in public health

The bottom line

- Business as usual is increasingly not an option
- Someone must assume responsibility for leading the public health delivery system
  - When to standardize
  - When to customize
- A focus on catalytic functions can improve public health delivery
- If not governmental public health, then who?