Panel 6: Setting Priorities

We have two sessions. Our next two panels are going to deal with an issue that in my experience has been one of the most overlooked and misunderstood and under-implemented elements in the community health improvement cycle, and that is priority setting. That being the case, what we have chosen to do is actually have two sessions that deal with the issue rather than one. We have two panelists who will be addressing this issue for us to get us started that will focus primarily on the science and methodology and begin to move somewhat into some of the practice issues. And our second panel will deal more fundamentally with implementation and practice implications for collaboration, ways in which we set priorities that accommodate the realities that we confront on the ground in communities, as well as alignment with public health.

So, our first panelist will be an invisible person at the podium. He is on the phone. He is Dr. Steven Teutsch, who's the Chief Science Officer at the Los Angeles County Department of Public Health. Steve had every intention of being with us and had a family emergency and has agreed graciously to do this from the phone, and we will move the slides forward to him. With that, Steve, as we had discussed, we do have the constraints. We can't stop you physically, since you're not in the room, but we still do have a 10 minute constraint on the initial -- or I'm sorry, 15 minute constraint on the initial panel presentation. Then we'll go to Dr. Beitsch, our second presenter, and then we will have -- I'll do a quick Q&A with you. And then we'll have 30 minutes of public comments and questions.

So, with that, Steve I'll turn it over to you. Well, thank you very much, Kevin. And thanks to you and the organizers for your flexibility and thanks too to my colleague, Les Beitsch for adapting to all of this. And I know I have a somewhat difficult task to talk about methodologies after lunch. And it sort of reminds me of a family of bears who've just had a long summer foraging and they've had a rich diet. And, as fall comes, they wander into a cave, settle down. And one bear then wanders to the front of the room and says, First slide, please.

So, let me talk a little bit about evidence-based decision making and hint at some of the issues that we can be -- that frameworks get at regarding priority setting.

So, the next slide shows some of the key points that need to be considered. Obviously, the first one is what is the decision where we're actually being asked to make. And given that we understand what the decision is, where do we set the evidence bare in terms of how good does the evidence need to be, and what kind of evidence do we bring to bear on the question?

How do we understand the relevant contextual factors and then how do you integrate all of that information and apply it in a way that makes sense?

And particularly then, what are the process that are needed to amalgamate all of that information to legitimize the decision-making process. The next slide illustrates at least one model of what I think of as a dynamic relationship between the evidence review and the scientific processes for decision making, and distinguish that from the evidence-based decision making processes itself.

So if we think about the decision makers over on the right bubble here who are making a set of decisions. I should be on slide three. I don't know, I don't see that on the screen but hopefully you do. If you see a set of decision makers who have a variety of decisions to be made, whether it's about outreach or policies or guidelines or clinical decisions, they frame the decisions and then throw it over the transom, if you will, to the people who have to pull the information together about the science, about the strength of the evidence, potentially some economic information. They organize that information in a systematic way. They toss it back to the decision makers who then need to integrate that information into what you see on the far right, which are a variety of contextual factors, the budget constraints, values, preferences, equity for example.

They integrate all of that and then presumably make a good decision. The next slide tries to illustrate the kinds of information that need to be brought to bear and a little bit of a way to organize thinking about that. The first is what Jonathan Lomis and his colleagues call scientific evidence. And that's really what we typically think of as coming out of rigorous scientific studies, it's knowable information, it's context independent. And in the clinical world, we think of that coming out of randomized clinical trials. It's about basic fundamental knowledge. The next kind of information that we see here is social science evidence. That's information that's knowable as well but is context dependent. That is, it varies from place to place. And then the third type is the part that's perhaps most prominent but also the most difficult to quantify, and that's the colloquial information, the idiosyncratic processes that go on that relate to political considerations and things of that nature.

So if one thinks about those different kinds of information that one can bring to bear, the problem, of course, is there is no simple technical solution then to what is the right answer. And to get to the right answer about what the decision should be, we frequently need to integrate that into deliberative processes, which in the context of our discussion, really means about engaging the right stakeholders in the community. If you go through the next two slides, we're going to be talking first about some of the scientific information. And so I want to run you through an example here, which is about how do you prioritize the recommended clinical preventive services. And I present this primarily as a way to illustrate how we bring together some of the information in a process that's already gone on.

So, what we did initially was to assess what we call the preventable burden. That is, how much of a problem can be prevented by delivering clinical preventive services whether we're talking about mammography screening, or whether we're talking about use of aspirin or tobacco cessation or whatever. What is the value or what is the cost-effectiveness of delivering that service?

And then to finally bring into bear what are the delivery rate for those high-priority services and how well are we doing?

So we looked at all of the services that were recommended by the US Preventive Services Task Force and the Advisory Committee on Immunization Practices on the next slide to begin to see, of all of those things which are known to be effective and are recommended, how do we use that information about preventable burden and cost-effectiveness to begin to array how we make better choices. And on this slide, you can see that we have on the second column, clinical preventable burden, that is how much can be prevented divided into five quintiles. We see the column labeled CE, cost-effectiveness, also divided into five quintiles. And so you could get a score from 1 to 5 on each, for a total of 10 if you were the highest on both dimensions. And you see at the top of this list Daily Aspirin Use, Childhood Immunization, Smoking Cessation, which would be those that have the greatest potential and the greatest value. At the bottom of the list, we see things that are also effective; but in fact, they actually have a small preventable burden and that are actually not all that cost-effective. What's not on this list, of course, are all the things that aren't recommended at all, many of which we do in the clinical setting. And I use this as an example primarily to show that one can begin to array these based on their preventable burden and cost-effectiveness. The next slide shows that if we take a measure, such as Quality Adjusted Life Years, that is sort of the combined burden of morbidity and mortality; and begin to say, well let's look at those services and say how many -- what percentage of people are currently receiving those services nationally.

You can see that some of the services, such a tobacco use, screening and brief intervention are only being received by 35% of people nationally, which suggests that we have about 1.5 million, or 1.3 million qualities that can be saved if we could increase that level up to 90%. And you can read down this list. And you can see that, based on the preventable burden and the level of service, you can begin to sort out those services which might provide the most value if they were delivered more systematically by a healthcare organization

or by a set of healthcare organizations working with community groups. The next slide talks about how do we begin to figure out about how interventions work and, going onto one more slide, we can see sort of how we've evolved our evidentiary standards over the last couple or three decades. One of the first groups that looked at evidentiary standards for the US was the US Preventive Services Task Force, which I've already alluded to. And they began by talking about a hierarchy of strength of evidence based largely on the rigor of steady design where the randomized clinical trial provided the highest standard. But this had a couple of challenges. First, it was a measure -- actually it was more a measure of efficacy than effectiveness. And secondly, it led to a rather tyranny in the randomized controlled clinical trial as being the sine qua non of evidence. There was also a growing recognition that evidence-based guidelines need to be based not so much on the rigor of the steady design but really on two things that we care about. How certain are we that something works and how big is the effect that that intervention might have?

So on the next slide, we can see that the guide to Community Preventive Services Task Force or the Community Preventive Services Task Force began to look at evidentiary standards applied to population-based interventions, by which they meant mostly policies and programs. And they developed a more robust evidentiary framework, which included a much broader array of study design so that we could look more broadly at things that were more appropriate for studies that involved the community with all their heterogeneity. And we also looked at the quality of the execution of those studies so that we would be able to incorporate a broader range of more appropriate studies in looking at figuring out what works. The next slide talks about some of the challenges as we looked at these population-based interventions. And some of these I'm sure are not surprising to you.

It's the challenges we face every day. And, unlike clinical preventive services, we're not looking at very specific technologies, and we know that interventions are often synergistic and they often require multiple different related components to be effective. There are also issues associated with the fidelity of implementation from one community to another where there are likely to be considerable differences in the available resources, the types of populations that need to be served so that they are all often adapted to different communities and, hence, are not a one-size-fits-all type of intervention. Before I get into some of the more details about the translational process, the next slide talks about an emerging area. And that's the use of models to begin to understand what works, and to begin to understand how all of these different interventions might fit together in ways that -- where we can better understand what the synergies are likely to be, what their applicability is likely to be in different settings, how the way they're implemented can affect different populations or different groups or what we might call the distributive impact, how they can be used in more of a forecasting manner so that we can anticipate what the benefits are likely to be over the longer term and the level of certainty. Clearly, the kinds of things we're often talking about in terms of community-based interventions are not amenable to the kinds of -- to many of the studies that we'd like to see. They take too long, particularly for those that have longer term effects. And they're too complicated to look at all of these complications.

So models are beginning to fill that void.

So they can be very informative, particularly where empirical studies can't be done or are simply impractical. The next slide illustrates what I think of in terms of the translational process itself. And if we think about on the left that there is a lot of research that goes on, that elucidates the basic sciences, but also the social sciences and understanding of basic processes that can lead to the development of health applications. And on the right side of this figure, that at some point it's worth getting those health applications introduced into health practice. And finally, what we really care about is that they actually make some type of a health impact. Steve, this is Kevin. Just a quick input. You're doing a great job of getting a lot of complex information across. Just wanted to give you a five minute heads up. All right, well I will move quicker -- that we then have a -- we see the evidence-based guideline process as the fulcrum to decide where

that should be. And as you move to the left, we get things introduced earlier with the problems we may not know how well they work. And to the right, as we move it to the right, then obviously there's a delay in getting it out to those who need to use them. Let's skip the next slide and go on to the one after that. I want to point out that there's a typology for classifying interventions by the level of scientific evidence. And here we could see that there are different categories which are proven, which we would think of those that meet the highest evidentiary standards. But in some areas, of course, we don't have those kinds of studies.

So then it's important to look at those that are likely to be effective, promising, or emerging. But in general, we want to select from the interventions that are higher up on this list wherever possible. And I want to then on the next slide go through some general principles as we think about what those evidentiary standards are for different studies. In general, we want to use effective interventions rather than those with weaker evidence. But in areas where we actually don't have very good evidence -- and the obesity world is certainly one of those, we should still strongly consider evidence-based interventions in other areas rather than going to interventions with weaker evidence in unproven areas. And while there may be at times reasons to go to interventions that are lower down on this list, those should only be entertained if the need is high and the harms are likely to be negligible. But when we do, these interventions then need to be subjected to rigorous evaluation. Let's skip through the next slide on key effectiveness questions, which relate to efficacy, safety, effectiveness, how interventions compare and how they differentially affect the population; and go to the following slide on some of the contextual information for decision making.

So, as we move away from, if you will, that scientific information, we're now talking about the social science factors. And I'm not going to go into the detail on each of these slides, but you can see that there's a set of clinical considerations, there are a set of economic considerations, which relate to their budget impact and budget constraints and the value. And on the next slide, we can see a set of legal and ethical considerations such as precedent, regulatory and legal constraints, the problem of regret if you don't do something. There's a set of feasibility issues and acceptability issues that relate to time frames. And I mention here that there are tradeoffs among things that happen over the shorter term versus some of the more important things that only happen over very extended periods. And then there are various -- on the next slide you can see -- administrative and management issues that are important to think about as part of the contextual information. The following slide shows a decision factor matrix. And what I've tried to illustrate here is a variety of the considerations on the left hand side that decision makers might consider in their decision. And I've shown across the top some clinical issues. But you could put population-based issues too. But I think it's easier in this framework. You can see here regulation coverage guidelines. And the question is, if you're a regulator, how do you think about something versus if you're a guideline developer or if you're making a community-based or an individual level decision. And the next slide then shows at least my vision about why we think about things in very different ways. You can see that if you're a regulator, such as the FDA, you're likely to think about things like the legal environment, that is your requirement, the efficacy and safety of a drug. Whereas if you're interested in coverage decisions, you may be more interested in the effectiveness in the real world, the economic and how they compare to other therapeutic alternatives.

So you can see in green those things that I think of as the primary set of considerations, yellow the secondary and in the background color still the tertiary considerations. The message here isn't that these are exactly correct, but it helps us begin to understand why different decision makers see things in different lights and how they weigh things differently. And the last slide, I'm just returning to the framework I began with, which is the framework that looks at scientific evidence, social science evidence and colloquial evidence as a way to begin to think about how we make decisions and the how we weigh those different components, and why it's so important then to incorporate that information into the deliberative processes that legitimize the decisions being made.

So I'll stop here and thank you very much. Hopefully, I didn't run over too much and turn it back to you, Kevin.

Thank you, Steve, and please stay with us as we're going to get to some broader Q&A in just a moment after Dr. Beitsch's presentation. Our next speaker is Leslie Beitsch, who is the Associate Dean for Health Affairs at Florida State University College of Medicine. Extensive experience in grappling with this issue. And I'm sure you'll join me in welcoming him to the podium.

Thank you. Excellent. Good afternoon, and it's Steve and I have been doing a lot of presentations together lately over the last month or so. But I don't think we've ever tried to do this on separate coasts simultaneously.

So Steve is just having breakfast, as we've just completed lunch. And that's usually about the time my phone rings or something, and it did, of course. I think most of you have received a copy or are intimately familiar with the recent IRS notice 2011-52, which you were probably given as part of this meeting.

Thank you. I've got to figure out what is beeping.

Thanks, again. There we go. If you look at Section 3 of the anticipated regulatory provisions, the implementation strategy, it has quite a bit to talk about an implementation strategy should be adopted, a written plan. It spends a bit of time talking about addressing the health needs that are identified in a community health needs assessment, as they call it; and gives you permission to collaborate, in fact encourages collaboration with others. And that -- we'll hopefully spend a little time touching back on how that relates to the world of public health. Prioritization is also noted. And I want to spend just a little time. I think Steve did a remarkably good job, postprandial, the lunch environment, talking to you over the phone with some very complicated evidentiary sort of slides. I'm going to speak a bit more about how you may take some of that information then in some very straightforward sort of ways, take that and put it into an opportunity to prioritize that huge amount of information that you've generated in your community health assessment type of process.

So, I think I don't like this but here we go. Let me try that. Yes. All right, you're going to hear tomorrow from Kay Bender, who's the CEO and President of the Public Health Accreditation Board. And what -- better known affectionately as PHAB. And PHAB is about to roll out an accreditation process that's a voluntary national public health accreditation process. I'm sure you've heard a little bit about that over the last day that you've been here. But there are three prerequisites for public health departments who are seeking accreditation. And as you can see community health assessment is sort of the basic foundation for those prerequisites. And then also a requirement for a community health improvement plan, which should be based then on the results of that community health assessment, as you might imagine; and an agency strategic plan which, among other things, would suggest those activities that the Health Department has to do as part of that overall community health plan, as well as certainly some internal operational kinds of activities. Why do I mention this?

My main point here is, just like the requirements for not-for-profit hospitals to demonstrate community benefit and perform community health assessments, so too must health departments. And so here, there's an alignment of a shared purpose. And I want to make -- just illustrate that point. I couldn't remember if I added this slide in here or not, so the guru of MAPP is actually -- was in this room earlier. There she is.

So if I misspeak, Julie will certainly assist me. MAPP stands for Mobilizing for Action through Planning and Process. And MAPP is part of a comprehensive approach to assessing your community that many local and soon coming to a state near you, a state health department type approach as well. And if you see -- well I can

do this. Okay, there's a local assessment of your community using the National Public Health Performance Standards and we'll talk about that ever so briefly. There's also a focus on changes assessment, which is a lot like a SWAT analysis that many of you are quite aware of. But more important for the discussion that we're having here is part of that comprehensive approach that MAPP takes is the community health assessment. And there's a couple of data points we should probably touch on is, how much assessment is going on out there?

The Public Health Accreditation Board recently completed a beta test in which 30 state, local, and tribal health departments in various stages of readiness for accreditation went through an accreditation-like process to essentially test the accreditation system that's planned. Likewise, ASTHO and NACCHO, the Association of State and Territorial Health Officials and National Association of County and City Health Officials, do surveys and profiles of their membership. And a couple of things we've learned from that, just to be very brief, is that there is a great deal of interest in an intent to apply for the new accreditation process again being rolled out later this fall. But up to date now there have been relatively low rates of health departments that have done all three of those prerequisites that I had shown you just a few minutes ago. And again, my main point here is that there's a tremendous opportunity then for synergy and alignment of what public health departments across the country need to accomplish; and with changes in the Affordable Care Act and community benefit requirements that hospitals now have, not-for-profit hospitals.

So let's move that into a very rapid discussion then of some of the things around prioritization. And we're going to just go talk a little bit about some of the mechanics of prioritization, selecting some tools, and with a little bit of luck I'll get through most of these slides.

So let's see where we go.

So just quickly, from my perspective and in trying to share prioritization, my thinking is that when you talk about health, it should be construed very broadly. And the World Health Organization, Institute of Medicine have some very broad definitions of health, that it's not merely the absence of disease. And picking a method or -- and I'll talk and offer you several here though it's hardly a comprehensive list -- that's less important than that you do a very thoughtful, engaging prioritization process itself. And so it has to include meaningful participation by that community. And there should be collaboration. Moreover, it should include the public health system. And let me take just 13 seconds or so to tell you what the public health system is. And I think you've probably heard it mentioned a few times over the last day or so. But it's government and its partners, public and private, who together provide public health services knowing and unknowing in every community, every city, state in the nation.

So together, and this is an IOM diagram from 2003, there's also one from a recent IOM repot in 2010 but they look very similar. And so there's a health delivery system that's certainly instrumental in that as is governmental public health.

So let's move on quickly. Prioritization, I don't think I need to belabor what a definition is with this group. And we do it all the time. But where we are often is everything -- there's a lot of people in this audience I know very well. And so what are you up to?

Well, I'm doing this, I'm doing 17. Great. I thought I had 15 minutes. I think I have five minutes. All right, you're doing lots of things but if everything is a priority, well then we know that nothing is.

So why prioritize?

Leadership direction is hugely important, resource limitations, urgency, you know, efficiency reasons, those kinds of things. It may be related to top-down kinds of things, bottom-up, leadership may call for it. But there's a lot of opportunities in going from a community health assessment to a community health improvement plan where there are many times when prioritization has to occur. And here's just a couple of examples that you might consider. Now, in selecting or choosing among, again, just some of the methods I will discuss here, you need to decide about the rigor way up front that you're going to devote to it.

So the level of participation, the number of participants that for you would be ideal, balanced with the amount of effort that you're going to put into this activity and how much energy you can apply to it.

So these are some of the methods I was hoping to talk about. I think maybe we'll see if we can't get through some real quickly. And then I had a couple of public health examples, which I'm sure we will not get to. But there, if someone asks a question. Dotmocracy is certainly the most simple way to go about doing things and not one I would recommend for something as important as a community health needs assessment. And yet there are some -- you might use it well within one of those systems. And again, it's a group voting process. Everyone is very actively involved and they get to vote early and often, sort of like Chicago politics. But the key benefit here is it's an extremely fast, rapid way to begin to get some sense of a lot of activities going on, which ones you can really devote more attention to. The detriment that you might have there is people may not be applying the same criteria to the decision-making process that they use. Nominal group process, nominal group planning a few things. It's usually a facilitated kind of thing where you ask a group to brainstorm. They list all the items that they can in turn so everyone participates. And that's a very important value. There's an opportunity to review and clarify and lump and split. Everybody votes in this process. It's done anonymously. But again, it promotes participation, as opposed to some people dominating that group. Often I think NGT can be used to generate a very significant list of areas that can then be further used in your prioritization kinds of things that I'm going to discuss here momentarily. Strategy grids or strategy maps, what they're about are selecting some criteria so it would be two criteria that are high and low on the X and Y axis. You create a 2 x 2 grid, which even a junior epidemiologist can do. You label your quadrants here in this particular diagram.

So you've got high and low importance on the Y axis and performance low and high on the X axis. And so, you in this case -- this is a National Public Health Performance Standards program and its results. And so you would place those within those four quadrants. And so the areas that had high priority but low results, let's see if I can do this one more time -- those are where your opportunities lie. By the same token, where this arrow is going here, if you've got there's low priority but high performance, you may shift resources then in that other direction, okay. The Simplex Method nuts and bolts, quickly this -- the advantage of the Simplex Method is, of course is its name. It's simple. But beyond that, it also generates widespread participation and can involve the entire community. The downside of that is the community, all the community members and participants who wish to play maybe less informed about the subtleties of those and the meaning of those issues.

So it may not be a meaningful engagement. But nonetheless, you develop set of closed-ended survey questions, provide options. You take that information and apply it to -- you average it and then you're able to rank those things. Now the Hanlon Method is a tried and proven method that is very popular and lots of folks use it. And just quickly, it gives you the criteria up front that you use for prioritization. And that's one of the attractive aspects of it. The magnitude of the problem is one of the criteria.

So, for example, the seriousness of the problem, so meningitis for example is a very serious problem but it's a relatively rare problem. The effectiveness of available interventions.

So PEARL, which is then you run all your proposed priority items through the PEARL test. And often this PEARL is applied in methods other than just Hanlon, and so propriety, economics, acceptability, resources and legality. Economics, is there a cost/benefit ratio, does it pay for itself?

Is it acceptable in the community, for example sex education or needle exchange programs may not work in some parts of the south that we're in right now. Resources, do you have those resources?

Are there grants available?

The legality of it, is it lawful in your jurisdiction?

And finally, the propriety, which is really the feasibility of doing it in your area. And maybe the last method I want to talk about quickly is Criteria Weighing. In this case, Hanlon gave you the criteria. In this case you develop your own. And you can have as many as you wish to have. You also weigh those criteria. And you can do it a number of ways, which I've suggested here. This requires some nimble multiplication and division techniques, which everyone in this room is fully capable of. Finally, a prioritization matrix is another option and can be used in combination potentially with some of the others. Again, you've got to identify your criteria, and I'll show you an example, probably my last slide, here in just a moment. You will weigh each criteria against another. And my example probably is the best way to look at that. And you can develop a summary matrix.

So let's just see what that looks like. And so here, okay so you've got a few criteria. You've got cost, effectiveness, acceptability, and how quickly you can implement that. That's -- those are rated from 1 to 10.

So cost is pretty high but effectiveness is highest at 10, okay. And so, you're looking at improved existing playgrounds.

So you rate that 1 to 10, it's about a 6 on the 10-point scale.

So 6 times 8, 48. Now this has to do with a vis-a-vie and how you might prevent it in elementary school children. I should have mentioned that when you looked at it firstly. But here you have an offering healthy lunch options in schools applied to this criteria, comes out with 200. And I think that gets you where you want to be. And so there you go. Good, stop that. Okay, so priority setting, again, I would urge you to do it creatively to engage and to do it meaningfully. Mix and match your methods if needed. Consider the barriers to implementation, that propriety or feasibility part of PEARL, that P. Use the data from all your assessment wisely. And again, to avoid bias, which I should have mentioned early, it's very important to establish the criteria up front so that there's no hidden agendas in that process. And I'm going to go ahead and just stop there and not give this example.

Thanks.

Thank you, Les. In the interest of time I'm going to go to questions after just asking one question of both of Les and Steve. Steve, in particular you've talked a lot about evidence and it really is important for us to have a strong evidence base and point of measurement for validating the work that we're engaged in. You talked about prioritizing within classes, and I think one of the conversations we've been having, in fact it's carried through a good part of this meeting, is thinking in terms of comprehensive approaches to health improvement. And, given what you've presented I think, and it's something I think we discussed to some extent in the run-up to this meeting, is in fact in order to validate these more comprehensive approaches, more research is needed. And in essence, what it creates to some extent is a Catch-22 because we have not invested sufficiently to date and/or don't have the sophisticated tools and methodologies to be able to assess

the relative effectiveness of more comprehensive approaches, which means that if we strictly apply these prioritization criteria, we may choose against more comprehensive approaches. How do we grapple with that thorny issue?

You're right, Kevin, it's a real dilemma. And I think it's part of that dilemma that's gotten us to the place we are in the current health system where we devote more and more resources to areas that are easier and easier to study. And I don't mean to suggest that the clinical care system is simple to study. But it's much more straightforward and we have methods and there's a lot of money going in to study that. And we end up then focusing on highly costly technologies rather than some of the more comprehensive and more complicated and difficult to evaluate kinds of initiatives.

So, I think there are a couple things that we actually need to do. And I know this isn't the time or place to really advocate for a major research agenda, but we certainly need that. But I think there is a plea that we begin to take advantage of some of the evaluation tools that we have, and modeling has certainly been underutilized. But more importantly, that when we implement programs, whether they're policies, multi-component kind of interventions, that we actually make sure we evaluate them properly and do that early. Many of the -- we need to be able to have models in our heads that we can begin to use that take us from, as Les and I've discovered, discussed in other venues, the capabilities, the resources and the processes through intermediate and longer-term outcome so that we can begin to make sure that we're on the right path to accomplish what it is that we're intending to do. And we need to have that in mind up front, and we need to have the information systems in place to allow us to begin to monitor what we're doing. Because many of the thing that we care most passionately about, in fact, in health are very upstream determinant where the outcomes are very long-term. And you know, it's been good research that allows us to say, You know, those early nurse home visits of early after birth, supporting those families has really important long-term outcomes in terms of violence and long-term health. We've got to make some of those investments. That doesn't mean we should defer all the decisions and say, Well, we'll do that in 30 years when we have the data. But it means that we need to put the kinds of evaluations in place so that we learn as we go, and we can make some midcourse corrections.

Thank you. Les, any comments on that?

We've got to make some of -- could you turn this mic up?

Or I can just yell louder. And that Institute of Medicine report looks at the changing legal environment in public health. And one of the key issues around implementing some of these strategies at the community level is that some of the -- for some of our most severe problems, as one of Steve's slides suggests, the evidence that we would most -- that something works for crucial and critical problems often is not fully there, again for all the research issues and other things that he's described. And yet the necessity to intervene, and obesity is a wonderful example where controlled clinical trials really aren't going to get what we want at the community level. And yet, to sit on the sidelines and not begin to implement some interventions would be foolhardy long-term.

So one of our recommendations in there very much tracks what Steve just suggested is that you do begin to implement some of these things under certain circumstances, but with very rigorous evaluations. And there's a call there at the HHS level to really begin to pull together a group of experts to look at some of that evidence base.

So I'll just leave it at that. Great. Questions and comments?

Good afternoon. Is this on?

Yeah. Gianfranco Pezzino, the Kansas Health Institute. I am a medical epidemiologist by training, and when I trained at CDC a couple of decades ago, it didn't take me very long to learn the basic principles of, how you say, priorities, how common, how severe, how preventable a condition in particular. Then I hit the field and it didn't take me very long to realize there was one important piece I hadn't learned yet. And that was how high is the level of concern in the community for a certain issue. And I think that, as quantitative scientists, sometime we tend to ignore that. And we need to resist the temptation to ignore that for several reasons. First of all, taking that into serous account that it deserves is the right thing to do if we want to serve the community. Second, it will make us gain a lot credibility with the community if we don't just ignore what we think we are doing or thinking wrong, but we just take that into consideration. And I think that was kind of implied in both presentations. But I thought it would be important to make that as an open statement as well. Great point. Next?

Chris Kochtitzky, the National Center for Environmental Health at CDC. And my question is sort of related to that last comment, which is I think prioritization is absolutely critical and I wondered if either or both of the panelists would talk about two things. One, the process for data selection and how you get engagement and buy-in from the community via how you -- when and how you select your data. And then secondly, how you do that in terms of prioritization so that in the end, the prioritization isn't just the public health system's priorities or the hospital priorities for that matter, but the entire community's priorities and that there's buy-in from all the players. Are there best practices or suggestions that either of you could offer to try to get to that level of buy-in in going through the process?

Great, we have one more comment and question, and then we'll go to the panel. And I'll just note that that is an issue that is also going to be dealt with in an in-depth way by the next panel. But please, third comment and question. Ron Bialek, Public Health Foundation. As Paul Halverson would say about the National Public Health Performance Standards program, what gets measured, gets done.

So you better be measuring the right things. And I think the same thing holds true with priorities, which both of you talked about priorities and evidence-based interventions.

So the priorities need to be the "right priorities" the interventions need to be the right interventions. My question relates to two elements I didn't hear addressed. One is understanding the root cause.

So, for instance in Orange County, Florida, we saw that syphilis was going up and they wanted to -- they were not following the CDC guidelines. They thought maybe they need to be. But until they realized there were HR problems and that there was a lot of turnover, they would never have gotten to the point where they would have been able to follow the guidelines.

So they looked at the root cause before going into the intervention.

So root cause I think is needed to be addressed in priority. Secondly, looking at what you control, what you influence, and what you have no control or influence over.

So I'd like for you guys to maybe address those a little bit. Okay, I'll give the panel a chance to respond. Just to paraphrase, how do you get buy-in from community as part of the priority-setting process, the broader community?

Be clear of what we're measuring. How do we explicitly integrate a consideration of root causes as part of the priority setting process?

And then the issue of what we can control and what we can't control. Just let me start since I can't see Les raising his hand at the moment. I think he's waiting for you to start us off, Steve. All right. Well, I think those are all good points. And in some ways out here we tend to -- we've thought about some of the issues of decision making in three different buckets. One is sort of with the evidence what do you know works?

What are your capabilities of your organization and your partners?

And then what are the expectations that are out there about what you're going to do?

And somehow you've got to move into that area where you both have the capabilities that matches the expectation and in areas where there's evidence. And that's part of the leadership task. But I also think that all of these questions get at the issue of framing things properly so that people can relate to the issues in a way that's meaningful. And I point out that historically and in the health world, we've thought about things in terms of diseases. And that's where we've invested and it's made huge progress whether we talked about cancer, infectious disease or heart disease. But 15 years ago, 20 years ago I guess now, the colleagues Mike McGinness and Bill Faghes talked about the actual causes of death. And we started talking, of course, then about tobacco and physical activity and nutrition and substance use. And more recently, we've gotten back to even better framing of all of this so that we can begin to understand the real upstream determinants of the social and physical environment and families and communities as well as then the individual behaviors, as well as the biological factors.

So it's really important that we get these things framed better.

So that's very sort of high level view and, of course, Ron is right. At the end of the day, if you're solving the wrong problem because you don't understand it right, you're not going to do it, you're not going to solve anything.

So somehow we've got to integrate them. But I would suggest that what Ron's talking about is very much what you do with the boots on the ground as opposed to initiating some of those discussions in the right kind of framework so that you can begin to move the entire agenda forward. And we have a big task ahead to do that. On the other hand, I do think community partners generally understand that the major problems that they face in their communities are very much these underlying determinants that we've got to address in more coherent ways in partnership with the clinical care system, hospitals, businesses, schools if we're really going to begin to get our arms around improving the health and moving the health indices of the country forward and beginning to get a more affordable healthcare system. Les?

I mean, Steve got all the good stuff, so let me just maybe add a couple of things. He did a very nice job; and you're right, Steve, I didn't raise my hand. You know, sort of getting at issues of community concern and buy-in have to be done well before the prioritization part of the process begins. And so these are things that are part of that whole planning process that you initiate before you ever have your first community meeting. If you've waited until then to do it, or trying to do that through the prioritization process that both Steve and I have tried to summarize very briefly, you are destined to an unsatisfactory result.

So what the whole definition then of meaningful engagement and meaningful participation is about that. But the National Public Health Performance Centers have been mentioned several times. These are opportunities to educate and inform your communities about what public health issues are. And so if people are coming to the table for prioritization kinds of activities and they're uninformed, you know, you missed your opportunity to have brought them into the greater and broader public health system. And I imagine that both our commentors Gianfranco and our gentleman from the National Center for Environmental Health wanted me to make that point. On root causes, Ron, I totally disagree with that. No. Ron, I think really, really

captured something I think is important on root cause. And generally the level of intervention that ought to be prioritized should be general. And, as you work through that kind of what you're -- I would be working more at the problem level than the intervention level. And then you go back and try to figure out what interventions best match the solutions to that problem. But root cause is going to be pretty crucial. And he brings back a great example from syphilis in Orange County.

So be careful in Orange County. The final issue that Ron mentioned was control versus non-control. Let me put a plug in for a paper that I authored with two other colleagues, Jack Moran and Grace Duffy, that if you read the Journal of Public Health Management and Practice, but hold on because it won't be there until January. And that is it's a great title, Why Don Berwick is Almost Right: How Public Health Quality Improvement Operates in Complex Systems. And it really gets at that very issue that if health departments, for example, choose to only work on those societal and public health issues that are fully within their own control, we won't accomplish a lot. We'll do a lot of things well in our neighborhood, but we won't change community health outcomes. Because the things that matter, we have so limited control over. Those things that are social determinants and others that many people have already mentioned today, those require partnerships and collaboration.

So that's instrumental bringing the groups to the table that are here today. Those are the issues that require the type of collaboration and community engagement of the public health system to really begin to tackle.

So, if you're only working on problems for which you have full control over, you know, think more broadly than that. Think bigger than that but make sure you have your house in order too.

So get all your processes and procedures in place so you can apply for PHAB accreditation, of course. But if you're going to work on quality improvement and all of those things at the broader societal level, you need to be dabbling well outside the center of your influence and control. Great. Next set of questions/comments?

Hi, thanks. Loel Solomon from Kaiser Permanente. I wanted to offer a couple of comments that I think are consistent with what's being said but perhaps extending a little bit. Firstly on this really interesting and important question of using the evidence base, I wanted to commend an IOM report that we commissioned along with a number of others around bridging the evidence gap around obesity prevention, which is a more generalizable framework. But it gets away from the tyranny of the randomized trial in these cases where complex multi-modal interventions and sources of the problem are at issue. And it gets us away from this challenge. There was no randomized trial that shows that putting sodas into vending machines in elementary schools was safe and efficacious. There ought not to be a randomized trial to engage the community to get those out.

So I think that's a really important framework for all of us to get our minds around. On this really important question of priorities, since this is a conversation these few days around best practices and thinking about community non-profit hospitals and their work there, I really wanted to emphasize this importance of looking for the sweet spot between community need, community opportunities to actually do something where is there political will or potential to actually make a difference, and then this third piece, which is where is the alignment with hospitals, strategy and their strategic imperatives and where the kind of will is of the leadership there. Not that that's dispositive, but that's another element, I think that needs to go into these improvement plans. And I think all that is just to say that the needs assessment is a critical piece of information. It's one piece of information that needs to be fold into a health improvement plan. And I think it's important for us to have improvement plans that really mobilize resources over a long term that are sustainable and engage the true assets at the hospital that we need to include all those kinds of considerations in the process. Great point, Loel. And another way of saying this, it's just as we -- it's important that it's salient to a broad spectrum of community stakeholders, that it be salient to the hospital as well. One more

comment and question. Hi, Lori Kneissl from Boston Children's. I just want to reiterate what you said because that's exactly where I was going. You can talk all about this process, but when you're in the hospital and you're trying to figure this out, there's only three points. It has to be part of your needs assessment, you have to look at what your -- we talk about it -- what expertise do we bring because it's no good for me to go try to find a doctor in the hospital who I'm going to try to convince him or her to get engaged in this. Unless it's where their passion lies, it's useless. And it also has to be what we say is around opportunities. We call it where there are community partners to work with.

So we see it as a Venn diagram with three. And that, you know, so you can go on and on but that's really where it comes down. And I think what it all comes down to is community dialog. And we call it a bi-directional dialog. And it really should come out of your community needs assessment. And I think part of what you have to do with the needs assessment is part of the conversation has been what's your quantitative data and what's you qualitative data. Because we can't be all things to all people. Everybody knows what the data says, but it's really when you do the focus groups and when you're talking to people and then it's a continuous dialog. You don't have to go -- in many ways, you don't have to go through a very formalized process because the needs kind of percolate up. And we've been doing needs assessments for 15 years. And I have to tell you, three of the four issues haven't changed one iota in 15 years. Great. Third comment and question, then we'll get panel response. It seems to me in my experience that there's a great deal of problem developing a rational approach to prioritization because the policy people, quite properly, think of prioritization as what comes -- what's most important, what's next most important?

So the order of importance, whereas managers think about priority in terms of what do we do first, what do we do second, what do we do third?

And managers generally understand that you don't necessarily do first what's the most important. And it seems to me that the solution there is for every single thing that you think is important, there should be an outline of the steps, the order of the steps to get it going. And almost inevitably the initial steps are very small, don't cost anything, don't disturb anybody. And that I think is the resolution. In other words, if someone thinks that the most important thing we've got to do is get away from solo practice to team practice with less of the work being done by physicians, that is the most important, well there's very few managers are going to put that really number one in terms of expenditure of energy and money. But if you outline what are the initial steps to get to that, then you resolve what I think is this very important difference of whether you're talking about most important or what do you do first, because then you'll be doing what do you of first and what's most important. And I'd be interested in the experts' reaction to that rather naive set of ideas. Great point. Just to recap, we've got the exhortation to have the right analysis for the right implementation, what are the -- you know, making sure we have the appropriate standards for what is validated, making sure we have alignment with hospital's strategy. In essence, salience is a two-way street. And I might reframe also, as Lori has talked about it is, because to a significant degree what we're talking about is building a common language where there's mutual education as a part of this process. And the last point, as raised by Bob, is this notion of sequence versus importance and how do we take into consideration that in fact we may take on multiple things, but sequencing and linkages are key considerations. Les is going first this time. Steve, I'm trying to give you a break this time.

Thanks, Les. You know, at the bottom of all these points, maybe not Bob's point so much is the issue of trust and relationships. You know, for example, to our colleague from Kaiser, the idea that you would craft a set of priorities in a community health improvement plan that didn't hit that sweet spot where everyone is a winner, you know, the win/win/win/win type of relationship, that's not a viable community health improvement plan ultimately. And so you know, there's an old adage in public health and anybody who ever responds to a disaster that if it's at the scene of a disaster you're first exchanging business cards, things aren't

going to go well. The same is true for if everybody's meeting one another when you're trying to establish priorities, you've missed the boat.

So you know, these things should be done as part of a long-term relationship building process. And you know, my hope would be that many of the people in this room are going to be part of building, or already are part of those long-term relationships. And so but let's not lose sight of one thing. The community health improvement plan should do something to improve the health in the community. If it improves only the bottom line of a hospital system or if it only checks off a box for the health department, that's not a community health improvement plan. There needs to be something about improvement that's part of it. To the person from Boston Children's, I have to say I'm not sure I'm with you on your comments. And the notion of a bi-directional dialog is somewhat redundant for me. The idea of a dialog is that it is bi-directional.

So, if you have to be admonished that it be bi-directional, then you haven't had dialog. And we're back to that whole trust and relationship building part that has to be a condition precedent to this whole process. Why you need a formalized process?

Because if you don't do it through a formalized process, a lot of people will preordain the outcome by establishing unwritten criteria that everyone in the community who's participating may not have bought into. And so by having a formalized process, it can be very much up-front and transparent and out in the open. Now maybe in your experience, and I suspect it is, those have amounted to the same thing. And that means you're doing something very right. And I think that's terrific. But in other places, that may not be the case. And then finally, let me just add one other piece. In building these relationships and maybe even trying to address Bob's very good point -- I like your categories -- is that you know, somehow some of that trust is built and how you hit some of these win/wins is, again I don't know that you want to tackle childhood obesity as your first kind of issue, even though it may be a key priority, you may want to be looking for low-hanging fruit or maybe that's fruit in your vending machine.

So before there's a project that took place in New Hampshire. I won't discuss the details of it. But you know, the idea was to reduce childhood obesity in this community in New Hampshire. Well, you know, what was their first metric?

Their first metric was the percentage of kids who bought a healthy afternoon snack after recess. Okay, and so you got to build that stuff.

So that was literally low-hanging fruit. It could have been a carrot too. But you know, so you got to think in terms of those how you build that relationship, that collaboration, before you begin to tackle some of these more complex kinds of matters. Steve, any follow-up?

Yes, I'll be brief, Ron. It seems to me that finding these alignments are absolutely critical. And I'm going to take one that is familiar to most of the hospitals and that's asthma where we know that there's a lot of uncompensated care for preventable hospitalizations and emergency room visits for asthma.

So there's clearly a vested interest in reducing that problem. And many of them have reached out to the communities to engage, to improve quality of care. But that also can be expanded to providing the support services that are necessary for those folks increasing accessibility. But then even moving further upstream into sort of the problems that lead to this such as health literacy that require more fundamental kind of changes.

So I think that there really is pretty good alignment and you can move folks along that dimension. By the same token, I think it's important to figure out, well where do we start?

And so I agree with that comment. And Les and I had the pleasure of listening to David Kendig last month, who talked about a project he was doing with George Isham at Health Partners in Minneapolis. And what they did was they took the major determinants of health, which had been laid out in the county health rankings, which are social determinants, environmental determinants, behaviors and clinical care; and then tried to define what the roles and responsibilities were of this managed care organization in each of those areas. And some of it was pretty simple and straightforward. Clinical care was their bread and butter, that was a primary.

Social determinants, they felt like these are really important and that they needed to be involved with. Health behaviors similarly were things the they needed to be involved with. Physical environment was not something that they really were able to impact that much. But they could begin to move down and understand, even within an organization like that, what their roles and responsibilities were to get the right kind of alignments so that you could begin to work optimally with all of the different community partners to begin to identify the specific actions that you can take and realizing where you've got leverage, where you've got capability and where you can begin to make a difference. Steve and Les, thank you very much. Please thank our panel.