Principles for Selecting Measures of Public Health Service Delivery

MPROVE Measure Selection Meeting

October 1-2, 2012

1. **Measures of public health system vs. clinical care system responsibilities.** Priority should be given to services/activities that are primarily the responsibility of the public health delivery system as opposed to the clinical care delivery system. For this reason, measures of primary prevention should receive priority over measures of secondary prevention such as clinical preventive services that are predominantly delivered through clinical providers.

2. **Agency-level vs. community-level measures of service delivery.** Agency-level measures focus exclusively on activities undertaken by local health departments and therefore may be easier to collect/obtain. For services that are predominantly or exclusively delivered by local health departments, agency-level measures are likely to be very useful for examining geographic variation in service delivery. However, agency-level measures may be of limited utility for studying variation in services that are delivered by multiple entities in the community, because such measures do not provide a complete view of service availability, volume/intensity, or quality. Similarly, agency-level measures have limited utility in cases where the entity that provides the service varies across states or communities. For these types of services, community-level measures are preferred, which assess service delivery within the local community regardless of which agencies/organizations provide the service. Community-level measures may be used in combination with agency-level measures in order to document the contributions made by governmental public health agencies to total community delivery. Agency-level measures may also be useful in cases where local health departments serve unique and high-priority populations that are not reached by other providers of the service in the community.

3. **Measures of “high value” services: primary prevention.** MPROVE should focus on measures of “high value” services that are expected to have a significant impact on preventable disease burden at an acceptable cost based on available evidence. This principle suggests a focus on primary prevention services as opposed to secondary prevention.

4. **Measures that have relevance in the context of health reform.** The Affordable Care Act gives the clinical care delivery system enhanced responsibility and accountability for the delivery of evidence-based clinical preventive services, while positioning the public health delivery system to play larger roles in primary prevention through policy, system, and environmental change strategies (e.g. PPTW, CTG, and Prevention and Public Health Fund). Measures selected for MPROVE should reflect this division of responsibility and give priority to services that characterize public health’s new roles under health reform.

5. **Heterogeneity in measures.** Given the relatively limited amount of prior experience with these measures, MPROVE should select a variety of different types of measures for study in order to create opportunities for learning the relative strengths and weaknesses of different measurement approaches. Similarly, MPROVE may wish to use some measures that can be compared/benchmarked against secondary sources of data in order to allow for tests of validity/reliability.

6. **Using bundles of related measures to characterize public health delivery.** Selecting bundles of related measures in specific areas of public health service delivery will give the MPROVE study more complete picture of geographic variation in delivery and provide a more granular understanding of service delivery contexts and processes. Bundles that include both community-level and agency-level measures may be particularly useful given principle #2 above.

Source: Public Health Practice-Based Research Networks National Coordinating Center