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ISPOR 2024
Women in HEOR Session

Economic EmpowerHERment: Unveiling Insights Into Public Health & Economic Research

Tuesday, May 7, 11:45AM–12:45PM

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An ISPOR *Women in HEOR* Session:

Economic EmpowerHERment:

Unveiling Insights Into Public Health & Economic Research

ISPOR 2024

Julia Slejko, PhD
University of Maryland

Women in HEOR Initiative

An ISPOR Women in HEOR Session

Economic EmpowerHERment:

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ISPOR 2024

ISPOR

Women in HEOR:

Founded in 2017 by Shelby D. Reed, RPh, PhD, ISPOR President 2017-2018

Vision—ISPOR Women in HEOR

- Support the growth, development, and contribution of women in HEOR
- Serve as a catalyst for women's leadership in the field
- Offer a platform for ISPOR women to collaborate, network, share, and mentor each other

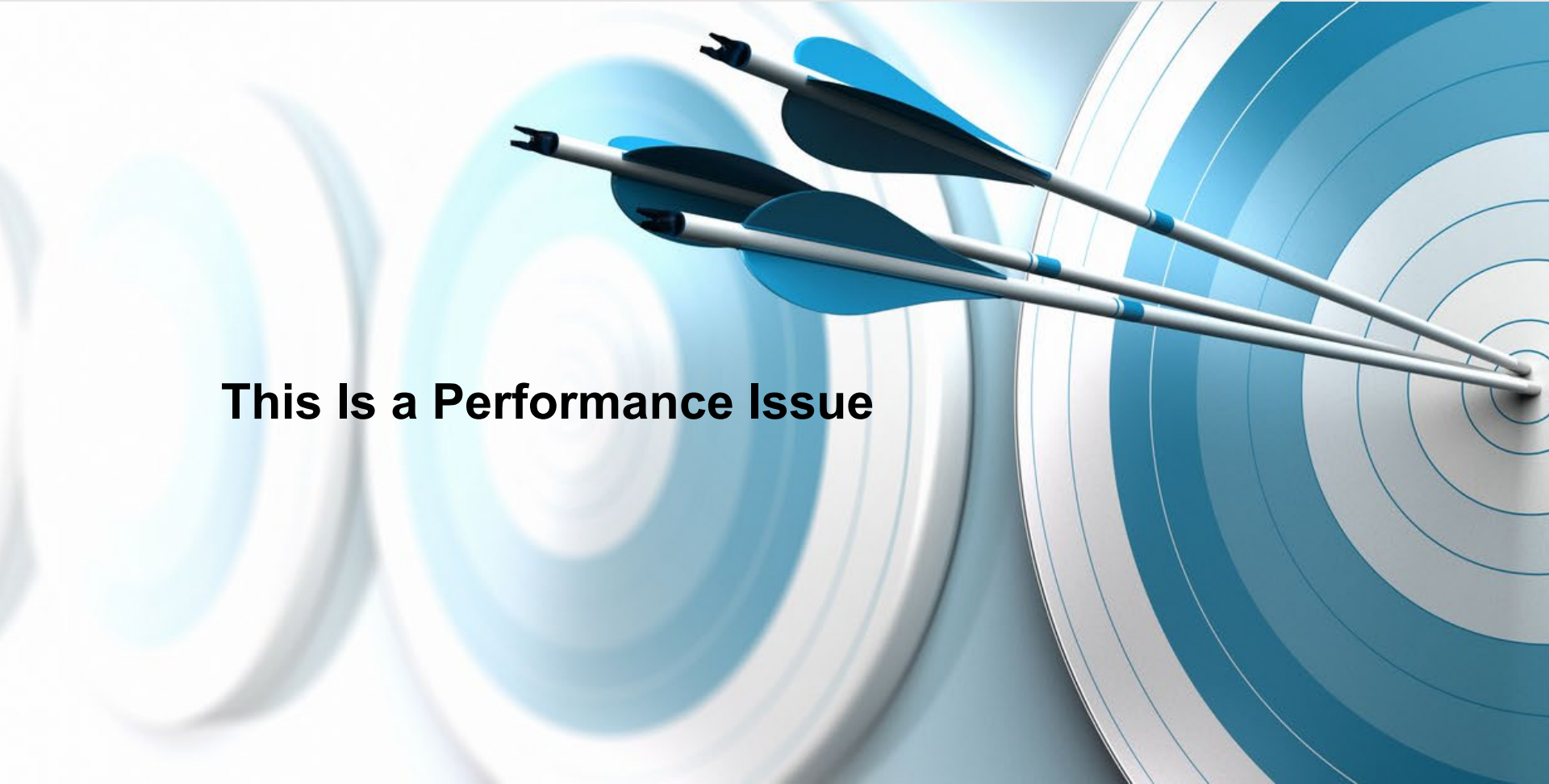
www.ispor.org/WomenInHEOR

Sessions, Networking, Dine Arounds, Cool Guy Allies

Women in HEOR Sessions

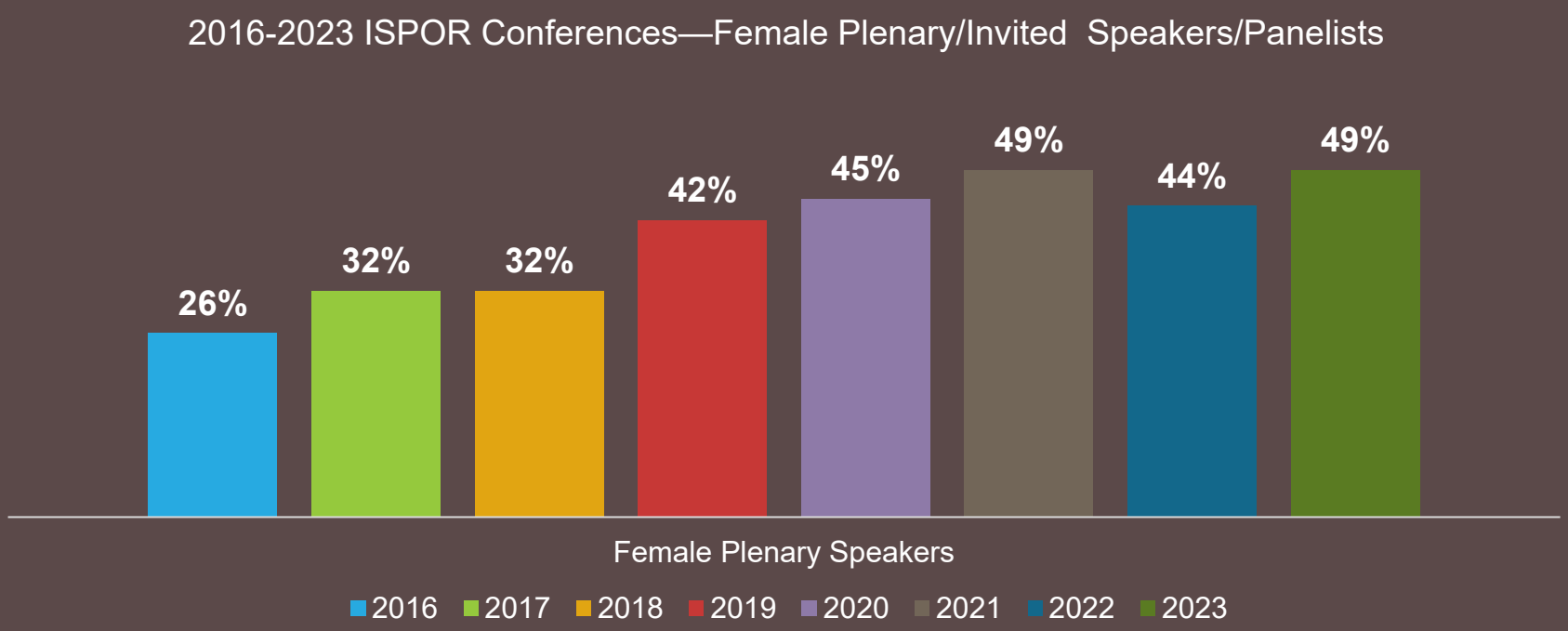
- *The Impact of the COVID-19 Pandemic on Gender Distribution of* Value in Health *Journal Authors*
- *Underestimated: Identifying and Addressing Mechanisms of Bias in HEOR*
- *Achievements, Lessons Learned, and Future Ambitions*
- *Strengthening Communication Practices*
- *Relationships Matter: How to Leverage Mentoring to Advance Your Career*
- *Lost in Translation: How to Optimize Communications in the COVID Era*
- *Unleashing the Leader Within You*
- *Adapting to the New Normal*
- *Mentors and Thought Leaders: Relationship Building for Career Success*
- *Enhancing Your Professional Toolkit*
- *Advancing Women in HEOR; Advancing Women in Healthcare (HBA)*

Diversity Dimensions



This Is a Performance Issue

ISPOR Conferences—Invited Speaker Gender Diversity



Learn More & Get Involved…

www.ispor.org/WomenInHEOR

- Initiative Overview and Video
- Upcoming Events
- Resources
- LinkedIn Discussion Group

Virtual Career Networking Session—Join Us!

Women in HEOR Virtual Event

- Wednesday, June 5 at 10:00AM EDT
- Look for more details to come on www.ispor.org/WomenInHEOR and our LinkedIn Discussion Group

Continue the Conversation…

Women in HEOR Reception

Meet, network, and continue the conversation:

- Tuesday, May 7
- 6:00PM–7:00PM
- Exhibit Hall at the ISPOR Booth

And at: www.ispor.org/WomenInHEOR

Poll #1

- Which Women in HEOR events have you attended in the past, or will you plan to attend this week? (multiple answers OK)
  - ISPOR Conference sessions
  - Dine arounds
  - Virtual Career Networking Events
  - I’m a first-timer

Poll #2

- Are you interested to attend the Virtual Career Networking Session on June 5, 10-11am ET? (multiple answers OK)
  - Yes
  - No
  - Not this one, but perhaps another time
  - I didn’t know about Virtual Networking until now

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An ISPOR *Women in HEOR* Session:

Economic EmpowerHERment:

Unveiling Insights Into Public Health & Economic Research

ISPOR 2024

Women in HEOR Panel

Phaedra Corso, PhD, MPA
Indiana University

Shelby D. Reed, PhD, RPh
Duke University

Julia Slejko, PhD
University of Maryland

Phaedra Corso, PhD, MPA
Indiana University

Economic EmpowerHERment:

Unveiling Insights Into Public Health & Economic Research

ISPOR 2024

BRING ON TOMORROW

EmpowerHERment: Public Health and Economics

Phaedra S. Corso, PhD, MPA

May 7, 2024

A story in 3-parts.....

1. The rise of economics research at the CDC.

2. The formation of a new school of public health at UGA, and the importance of economic evaluation/health economics as a core academic and research mission.

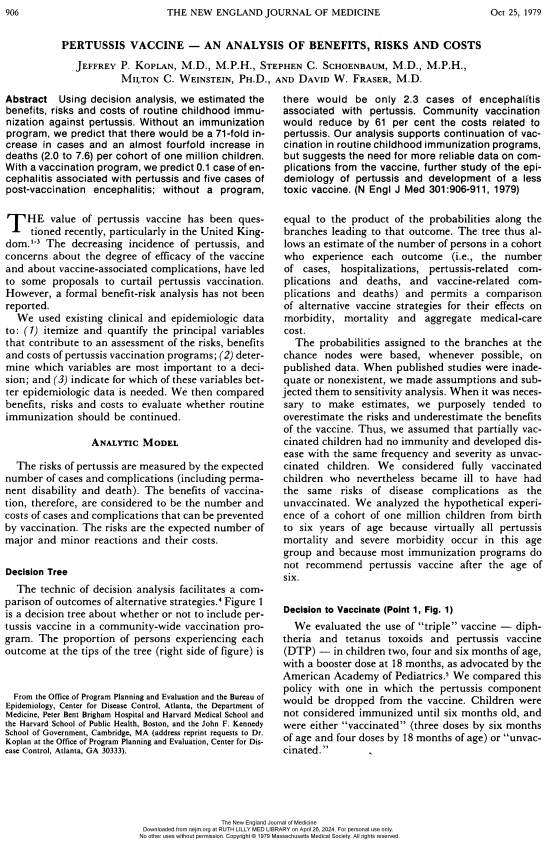
3. The launch of new university-wide research institutes at IUI, and the role that economic evaluation/health economics will play.

BRING ON TOMORROW

Part 1: CDC and Early Applications of Economics

Sencer DJ, Axnick NW. Cost benefit analysis. International Symposium on Vaccination against Communicable Diseases, Monaco 1973. *Symp Series Immunobiol Standard.* 1973; 22:37–46.

Koplan JP. The use of cost-effectiveness analyses at a federal public health agency. *Drug Information J*. 1988;22:407-10.



906 THE NEW ENGLAND JOURNAL OF MEDICINE Oct 25, 1979

PERTUSSIS VACCINE — AN ANALYSIS OF BENEFITS, RISKS AND COSTS

JEFFREY P. KOPLAN, M.D., M.P.H., STEPHEN C. SCHOENBAUM, M.D., M.P.H., MILTON C. WEINSTEIN, PH.D., AND DAVID W. FRASER, M.D.

Abstract Using decision analysis, we estimated the benefits, risks and costs of routine childhood immunization against pertussis. Without an immunization program, we predict that there would be a 71-fold increase in cases and an almost fourfold increase in deaths (2.0 to 7.6) per cohort of one million children. With a vaccination program, we predict 0.1 case of encephalitis associated with pertussis and five cases of post-vaccination encephalitis; without a program, there would be only 2.3 cases of encephalitis associated with pertussis. Community vaccination would reduce by 61 per cent the costs related to pertussis. Our analysis supports continuation of vaccination in routine childhood immunization programs, but suggests the need for more reliable data on complications from the vaccine, further study of the epidemiology of pertussis and development of a less toxic vaccine. (N Engl J Med 301:906-911, 1979)

THE value of pertussis vaccine has been questioned recently, particularly in the United Kingdom.[1-3] The decreasing incidence of pertussis, and concerns about the degree of efficacy of the vaccine and about vaccine-associated complications, have led to some proposals to curtail pertussis vaccination. However, a formal benefit-risk analysis has not been reported.

We used existing clinical and epidemiologic data to: *(1)* itemize and quantify the principal variables that contribute to an assessment of the risks, benefits and costs of pertussis vaccination programs; *(2)* determine which variables are most important to a decision; and *(3)* indicate for which of these variables better epidemiologic data is needed. We then compared benefits, risks and costs to evaluate whether routine immunization should be continued.

ANALYTIC MODEL

The risks of pertussis are measured by the expected number of cases and complications (including permanent disability and death). The benefits of vaccination, therefore, are considered to be the number and costs of cases and complications that can be prevented by vaccination. The risks are the expected number of major and minor reactions and their costs.

Decision Tree

The technic of decision analysis facilitates a comparison of outcomes of alternative strategies.[4] Figure 1 is a decision tree about whether or not to include pertussis vaccine in a community-wide vaccination program. The proportion of persons experiencing each outcome at the tips of the tree (right side of figure) is equal to the product of the probabilities along the branches leading to that outcome. The tree thus allows an estimate of the number of persons in a cohort who experience each outcome (i.e., the number of cases, hospitalizations, pertussis-related complications and deaths, and vaccine-related complications and deaths) and permits a comparison of alternative vaccine strategies for their effects on morbidity, mortality and aggregate medical-care cost.

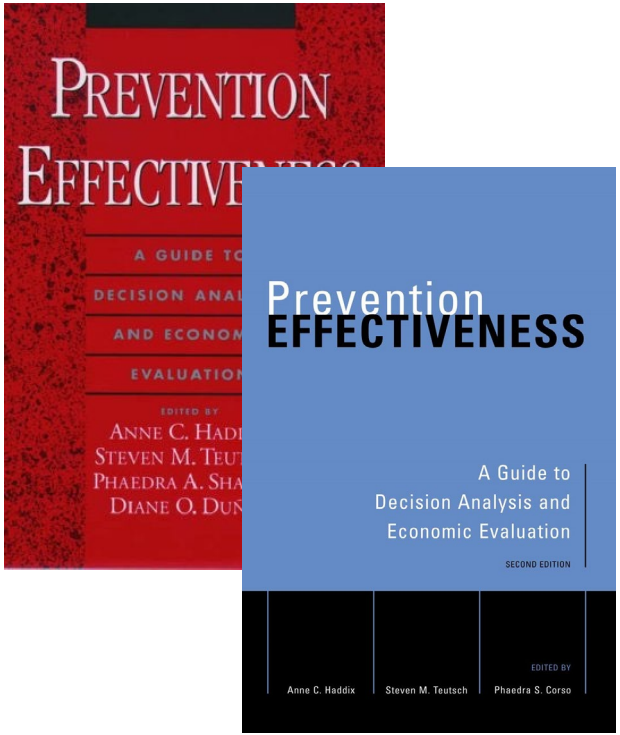
The probabilities assigned to the branches at the chance nodes were based, whenever possible, on published data. When published studies were inadequate or nonexistent, we made assumptions and subjected them to sensitivity analysis. When it was necessary to make estimates, we purposely tended to overestimate the risks and underestimate the benefits of the vaccine. Thus, we assumed that partially vaccinated children had no immunity and developed disease with the same frequency and severity as unvaccinated children. We considered fully vaccinated children who nevertheless became ill to have had the same risks of disease complications as the unvaccinated. We analyzed the hypothetical experience of a cohort of one million children from birth to six years of age because virtually all pertussis mortality and severe morbidity occur in this age group and because most immunization programs do not recommend pertussis vaccine after the age of six.

Decision to Vaccinate (Point 1, Fig. 1)

We evaluated the use of "triple" vaccine — diphtheria and tetanus toxoids and pertussis vaccine (DTP) — in children two, four and six months of age, with a booster dose at 18 months, as advocated by the American Academy of Pediatrics.[5] We compared this policy with one in which the pertussis component would be dropped from the vaccine. Children were not considered immunized until six months old, and were either "vaccinated" (three doses by six months of age and four doses by 18 months of age) or "unvaccinated."

From the Office of Program Planning and Evaluation and the Bureau of Epidemiology, Center for Disease Control, Atlanta, the Department of Medicine, Peter Bent Brigham Hospital and Harvard Medical School and the Harvard School of Public Health, Boston, and the John F. Kennedy School of Government, Cambridge, MA (address reprint requests to Dr. Koplan at the Office of Program Planning and Evaluation, Center for Disease Control, Atlanta, GA 30333).

Part 1 (cont.): CDC and the PE Movement



The Value of Prevention: Experiences of a Public Health Agency

Phaedra S. Corso, PhD, Stephen B. Thacker, MD, MSc, Jeffrey P. Koplan, MD, MPH

In his recent article about the history of the Society for Medical Decision Making (SMDM), Fryback notes that at their 1st meeting in 1979, members of SMDM discussed the sensibility of devoting careers to the use of newly developing and not very popular quantitative methods to guide medical decision making.[1] On the prevention side of decision making, we had similar discussions. David Sencer, former director of the Centers for Disease Control and Prevention (CDC), wrote in 1975 that "From a public investment standpoint, we need to employ an economic-type of thinking in planning disease prevention programs."[2] His article briefly summarized how benefit-cost analysis, as a "type of policy analysis still in a developing stage," could be useful for developing priority criteria and as a tool to determine "the dollar worth of a prevention expenditure." As the recent essays published in *Medical Decision Making* reflect on the beginnings and future of medical decision making,[3-5] in this article we will similarly describe how CDC has used formal economic methods for public health decision making.

Prevention in health is best understood in the context of 3 levels of prevention—primary, secondary, and tertiary. Primary prevention attempts to reduce the incidence of disease and injury (e.g., polio vaccination), whereas secondary prevention is focused on early detection and prompt and effective interventions (e.g., screening for colon cancer). Tertiary prevention provides measures to reduce or eliminate long-term impairments and disabilities (e.g., screening for retinal complications of diabetes).

CDC programs include a full spectrum of contemporary public health concerns, for example, occupational safety and health, environmental health, chronic diseases, maternal and child health, injuries and violence, and infectious diseases. These programs are delivered primarily through state and local health agencies. Agency activities range from providing leadership, conducting applied research, building capacity and a public health infrastructure, to developing standards and guidelines and disseminating credible public health information. Public health, as with all sectors of public expenditure and all aspects of health care, is scrutinized for its value, both internally—how does one public health intervention compare in value with another—and externally—how does a public health intervention compare in societal value with one competing for resources in education, transportation, and security? To meet these needs, the expansion of sciences at CDC has increased from the traditional applications of microbiology, epidemiology, and statistics to behavioral and social sciences, program evaluation, economic evaluation, and the decision sciences.

To provide information on the economic feasibility of interventions of interest, CDC has relied increasingly on the use of cost analysis, cost-effectiveness analysis, cost-benefit analysis, and the decision sciences. This article provides a historical perspective on the use of economic tools at CDC, which includes several examples of economic evaluations that have been instrumental in influencing public health policy; it will describe the present use of economic evaluation at CDC by highlighting some challenges encountered in its use. Future directions for research and methodologic improvements also are discussed.

EARLY APPLICATIONS OF ECONOMIC METHODS

During the time when quantitative methods to inform clinical decision making were in their infancy, economic evaluations in the public health arena were used primarily to justify existing prevention interventions where new scientific evidence or public concern threatened their existence. Immunization programs designed to protect against childhood diseases have been particularly susceptible to such controversies. First,

Received 15 May 2002 from Epidemiology Program Office, Centers for Disease Control and Prevention (PSC, SBT), and Woodruff Health Sciences Center, Emory University (JPK).

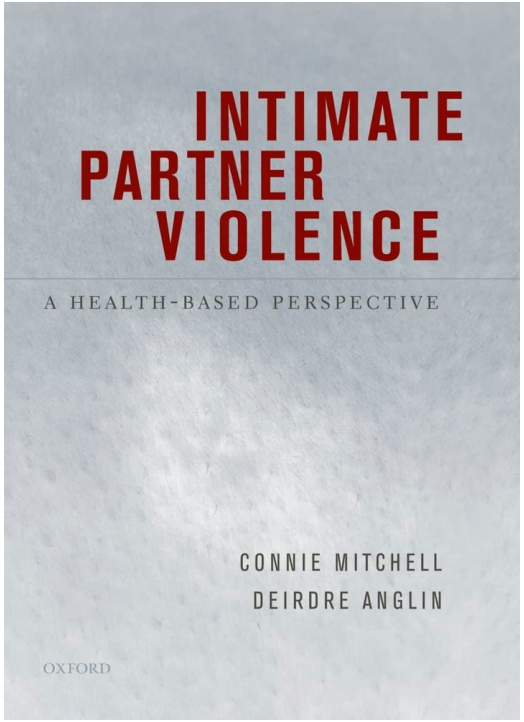
Address correspondence and reprint requests to Dr. Corso at 4770 Buford Highway, Mailstop K-73, Atlanta, GA 30341; e-mail: pcorso@cdc.gov.

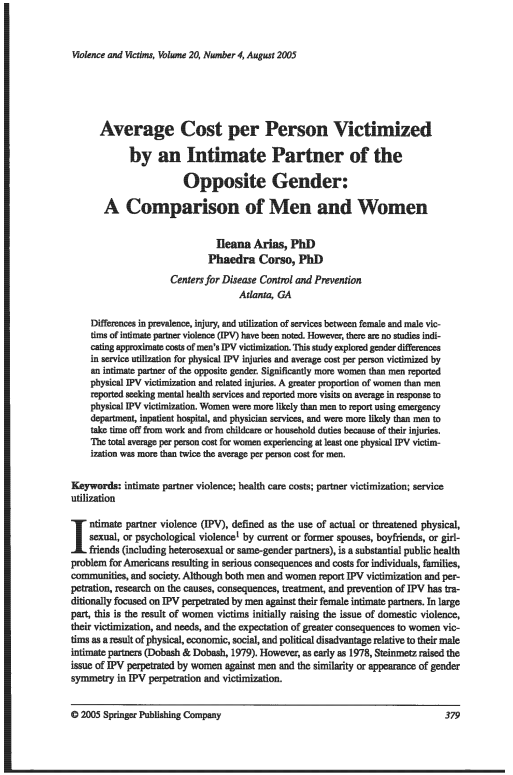
DOI: 10.1177/027298902237712

Part 1 (cont.): CDC and the PE Movement

- 1995: The Steven M. Teutsch Prevention Effectiveness Fellowship program
- A 2-yr post-doctoral research program focusing on the application of quantitative methods to the prevention of disease and injury.
- Applicants have doctoral degrees in: economics, decision sciences, health sciences, industrial engineering or operations research, public policy and analysis, applied mathematics or modeling, or related field.
- 230+ graduates of the PE Fellowship have generated almost 4,500 publications and contributed to key policies and programmatic advances over the years.

Part 1 (cont.):





Violence and Victims, Volume 20, Number 4, August 2005

Average Cost per Person Victimized by an Intimate Partner of the Opposite Gender: A Comparison of Men and Women

Ileana Arias, PhD
Phaedra Corso, PhD
Centers for Disease Control and Prevention
Atlanta, GA

Differences in prevalence, injury, and utilization of services between female and male victims of intimate partner violence (IPV) have been noted. However, there are no studies indicating approximate costs of men's IPV victimization. This study explored gender differences in service utilization for physical IPV injuries and average cost per person victimized by an intimate partner of the opposite gender. Significantly more women than men reported physical IPV victimization and related injuries. A greater proportion of women than men reported seeking mental health services and reported more visits on average in response to physical IPV victimization. Women were more likely than men to report using emergency department, inpatient hospital, and physician services, and were more likely than men to take time off from work and from childcare or household duties because of their injuries. The total average per person cost for women experiencing at least one physical IPV victimization was more than twice the average per person cost for men.

Keywords: intimate partner violence; health care costs; partner victimization; service utilization

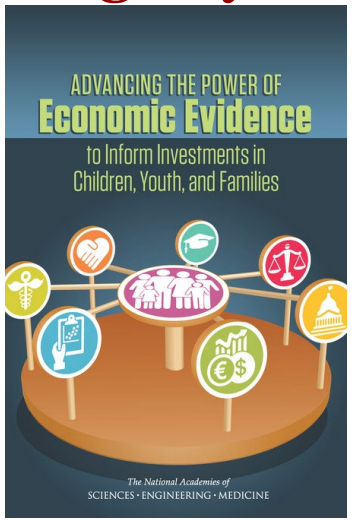
Intimate partner violence (IPV), defined as the use of actual or threatened physical, sexual, or psychological violence[1] by current or former spouses, boyfriends, or girlfriends (including heterosexual or same-gender partners), is a substantial public health problem for Americans resulting in serious consequences and costs for individuals, families, communities, and society. Although both men and women report IPV victimization and perpetration, research on the causes, consequences, treatment, and prevention of IPV has traditionally focused on IPV perpetrated by men against their female intimate partners. In large part, this is the result of women victims initially raising the issue of domestic violence, their victimization, and needs, and the expectation of greater consequences to women victims as a result of physical, economic, social, and political disadvantage relative to their male intimate partners (Dobash & Dobash, 1979). However, as early as 1978, Steinmetz raised the issue of IPV perpetrated by women against men and the similarity or appearance of gender symmetry in IPV perpetration and victimization.

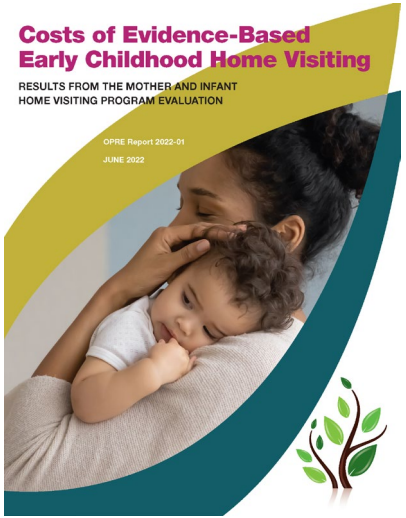
Part 1 (cont.): CDC and economics today

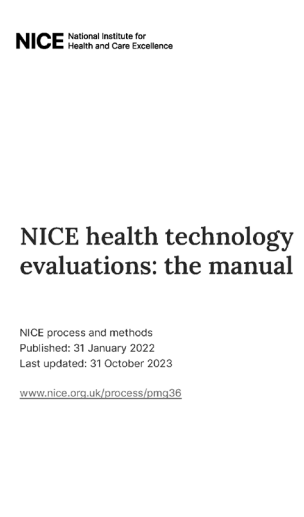
- At CDC, systematic reviews of the economic evaluation of interventions informs policy decisions for the

Community Preventive Services Task Force

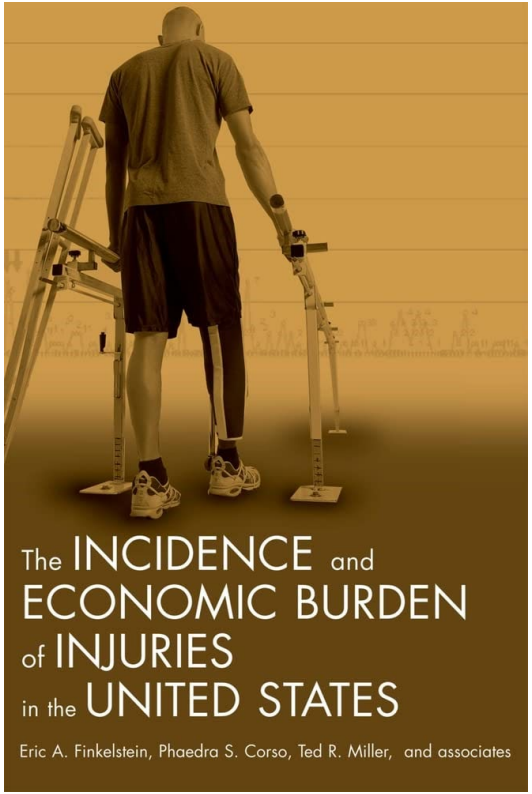
Part 1 (cont.): Economic evaluation and public health policy making beyond CDC and the US







Part 1 (cont.): Equity Issues in the use of Human Capital methods to estimate Economic Burden…..



Part 1 (cont.): Equity Issues in the use of CEA

Cambridge Quarterly of Healthcare Ethics (2023), 32: 2, 154–162
doi:10.1017/S0963180122000330

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COMMENTARY

QALYs, Disability Discrimination, and the Role of Adaptation in the Capacity to Recover: The Patient-Sensitive Health-Related Quality of Life Account

Julia Mosquera

Institute for Futures Studies (IFFS), Stockholm, Sweden
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Introduction

Quality-Adjusted Life Years (QALYs) and Disability-Adjusted Life Years (DALYs) are two of the most commonly used health measures to determine resource prioritization and the population burden of disease, respectively. There are different types of problems with the use of QALYs and DALYs for measuring health benefits. Some of these problems have to do with measurement, for example, the weights they ascribe to health states might fail to reflect with exact accuracy the actual well-being or health levels of individuals. But even if these weights represent accurately the well-being levels of individuals, there is room for questioning whether these measures capture everything that we care about in these cases, or whether there are important issues that they leave out, including considerations of fairness or equality. In this regard, the measures have been criticized for treating the aggregation of small benefits as greater than the aggregation of fewer but bigger benefits,[1] for disregarding fair chances in favor of utility maximization,[2] and for raising problems when applied in the context of variable population size.[3] Perhaps one of the most pervasive ethical issues that has been associated with the use of these measures is the fact that they seem to discriminate against disabled people.[4] Since the measures assume that disabled people have lower well-being and a shorter life span, treating a disabled person's medical condition contributes less to the maximization of years of life with good health than treating a non-disabled patient's medical condition.

In his paper "Disability Discrimination and the Patient-Sensitive Health-Related Quality of Life," Lasse Nielsen proposes an amendment to the use of QALYs with the aim of avoiding discrimination against disabled patients. According to his account, the Patient-Sensitive Health-Related Quality of Life account, the only variable relevant to determine a patient's health-related quality of life per year and thus the ranking of health interventions between patients, should be the disposition of patients to respond to a given medical treatment. In this paper I show how, under some of the most plausible understandings of the capacity of patients to respond to a given medical treatment, his amended approach can in some circumstances lead to unfairly deprioritizing some disabled patients over non-disabled ones. To understand the magnitude of this challenge, it is necessary to determine the prevalence of these types of cases. This is a highly contextual, case-by-case project that would involve finding out which medical conditions would behave in which way, for which treatments, and in connection with which unrelated, pre-existing conditions.

Disability Discrimination in DALYs and QALYs

DALYs result from the sum of two components, one of which incorporates the discounting of years of life lived with a disability. DALYs result from the sum of Years of Life Lost (YLL) and Years of Life lost due to Disability (YLD). The first component of the sum, YLL, is prima facie disability-discrimination-free since it measures the badness of a person's death by reference to the number of years of life lost due to death occurring at an age earlier than a given, constructed average life expectancy (e.g., ~80 years), thus treating the death of a disabled and a non-disabled person equally. The second component of the sum, YLD,

Cambridge Quarterly of Healthcare Ethics (2015), 32: 2, 202–215
doi:10.1017/S0963180115001745

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ARTICLE

Cost-Effectiveness and the Avoidance of Discrimination in Healthcare: Can We Have Both?

Kasper Lippert-Rasmussen

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Corresponding author. Email: lippert@ps.au.dk

Abstract

Many ethical theorists believe that a given distribution of healthcare is morally justified only if (1) it is cost-effective and (2) it does not discriminate against older adults and disabled people. However, if (3) cost-effectiveness involves maximizing the number of quality-adjusted life years (QALYs) added by a given unit of healthcare resource, or cost, it seems the pursuit of cost-effectiveness will inevitably discriminate against older adults and disabled patients. I show why this trilemma is harder to escape than some theorists think. We cannot avoid it by using age- or disability-weighted QALY scores, for example. I then explain why there is no sense of "discrimination" on which discrimination is *both* unjust, and thus something healthcare rationing must avoid, *and* something cost-effective healthcare rationing inevitably involves. I go on to argue that many of the reasons we have for not favoring rationing that maximizes QALYs outside the healthcare context apply in healthcare as well. Thus, claim (1) above is dubious.

Keywords: ableism; ageism; compounding injustice; discrimination; distributive justice in healthcare; healthcare rationing; moral worth; QALY

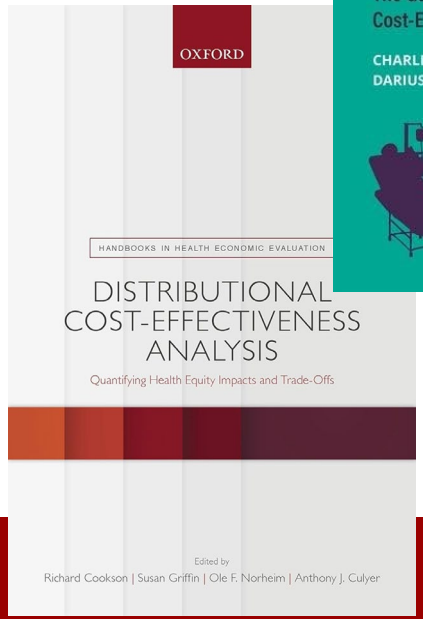
Introduction

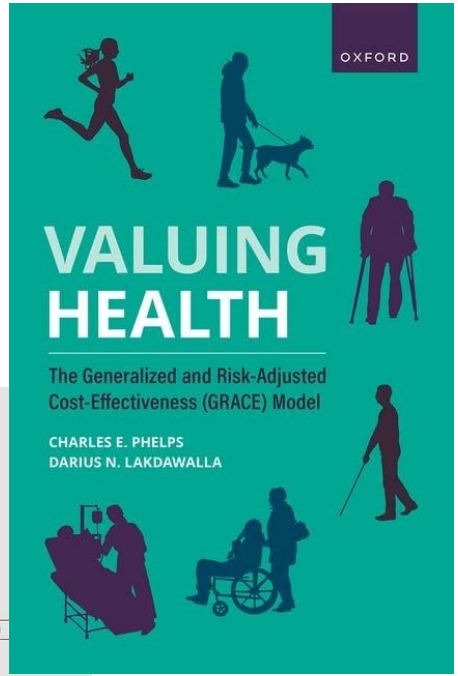
When is a scheme of healthcare rationing, for example, a public healthcare system's policy regarding which treatments to offer and which not to offer, morally justified?[1] This is obviously a hugely complex issue, but two thoughts are familiar:

1) A scheme of healthcare rationing is justified only if it does not discriminate against older adults and the disabled (the *Non-Discrimination Condition*, or simply *Non-Discrimination*).[2]
2) A scheme of healthcare rationing is justified only if it is cost-effective (the *Cost-Effectiveness Condition*, or *Cost-Effectiveness*).

Both of these, as necessary conditions, look right. Healthcare rationing which is racist, or sexist, or religious, is clearly unjustified. If that is so, why is the same not true of ageist and ableist rationing, which is the two sorts of discrimination this article focuses on?[3] The non-discrimination condition is very plausible. Similarly, cost-effectiveness seems correct because a cost-ineffective rationing scheme is wasteful—in it, we could have gotten more health benefits from the resources we have, and some patients pay the price for that.[4]

But now a problem arises. It is widely assumed that healthcare cost-effectiveness is a matter of maximizing the sum of quality-adjusted life-years (QALYs) obtained from the available healthcare resources.[5] But it is not hard to see that, quite often, resources used treating older adults and disabled people will be used less cost-effectively than they would have been had they been used in the treatment of young and non-disabled people. Often, a treatment that saves the life of an older adult patient predictably results in fewer extra life-years at a lower level of health than the same treatment, offered to a younger





Part 2: Adding EE curricula and research to a new school of public health

UNIVERSITY OF GEORGIA
College of Public Health
Health Policy & Management
Economic Evaluation Research Group

Courses in Economic Evaluation:

- HPAM 8400 Policy and economic analysis in public health
- HPAM 8450 Policy evaluation in public health
- HPAM 8850 Cost-effectiveness in health and medicine
- HPAM 8900 Special topics in health administration: Introduction to economic evaluation methods

BRING ON TOMORROW

Part 2 (cont.):

11 **A COMPARISON OF WILLINGNESS TO PAY TO PREVENT CHILD MALTREATMENT DEATHS IN ECUADOR AND THE UNITED STATES**

doi:10.1136/injuryprev-2012-040590q.11

[1]P Corso, [2]M Roldos. [1]University of Georgia, USA; [2]Ciudadanía Activa, Ecuador

Background Assessing societal willingness-to-pay (WTP) is one approach for monetising potential benefits of an intervention. In the field of child maltreatment (CM), such estimates are scarce and have rarely been compared between populations from different countries.

Aims/Objectives/Purpose This study estimates WTP for an intervention intended to reduce the mortality risk associated with CM, comparing an Ecuadorian to US population.

Methods We used the contingent valuation method to ask WTP in increased annual taxes (in US$) for a 50% reduction in CM mortality risk. The US population (n=117) was selected by random-digit dial in 2008. The Ecuadorian population (n=78) was selected by convenience from different shopping districts in 2012. The 2008 WTP estimates were inflated to 2012 US$ for comparison. The maximum likelihood function was estimated using interval regression in STATA. Other covariates tested in the model included age, gender, race, and history of CM abuse.

Results/Outcomes The WTP for a 50% reduction in the risk of a child being killed by a caretaker or parent was $167 ($146–$190, 95% CI) in Ecuador, and $215 ($185 to $246, 95% CI) in the US, which was significantly different at p=0.08 when tested in the reduced model. In the full model, none of the covariates including country were significant.

Significance/Contribution to the Field WTP to prevent CM death varies marginally from one population to another, likely tempered by differences in purchasing power. Given the overall low probability of CM death, the value placed on a life saved from CM in either population is considerable.

Safe to Sleep Hospital Initiative Parent Survey Results

June 2017

Violence Against Women
Volume 14 Number 9
September 2008 1054-1064
© 2008 Sage Publications
10.1177/1077801208321985
http://vaw.sagepub.com
hosted at
http://online.sagepub.com

Propensity for Intimate Partner Abuse and Workplace Productivity

Why Employers Should Care

Emily F. Rothman
Boston University School of Public Health
Phaedra S. Corso
University of Georgia, College of Public Health

It has been demonstrated that intimate partner violence (IPV) victimization is costly to employers, but little is known about the economic consequences associated with employing perpetrators. This study investigated propensity for partner abuse as a predictor of missed work time and on-the-job decreases in productivity among a small sample of male employees at a state agency ($N = 61$). Results suggest that greater propensity for abusiveness is positively associated with missing work and experiencing worse productivity on the job, controlling for level of education, income, marital status, age, and part-time versus full-time employment status. Additional research could clarify whether IPV perpetration is a predictor of decreased productivity among larger samples and a wider variety of workplace settings. Employers and IPV advocates should consider responding to potential IPV perpetrators through the workplace in addition to developing victim-oriented policies and prevention initiatives.

Keywords: *batterers; intimate partner violence; productivity*

Increasingly, employers are considering the effect of intimate partner violence (IPV) on the workforce and becoming involved in prevention efforts. A 2003 report by the U.S. Centers for Disease Control and Prevention (CDC) revealed that IPV victimization causes a total of 14.6 million days of lost productivity among women in the United States every year, and that each time an employed woman is assaulted by her partner, she misses an average of 7 days of work and requires $800 worth of medical and mental health care (National Center for Injury Prevention and Control, 2003). Of the $5 billion in medical costs and productivity losses resulting every year from IPV-related injuries to women, it has been suggested that the private sector incurs more than 50% of this burden through payments to private and group health insurance and the provision of annual and sick leave benefits (Corso, 2005).

Implementation of a Statewide Policy Mandating School-Based Fitness Assessment Screening, Georgia: 2018

Phaedra S. Corso, PhD, Justin Ingels, PhD, Janani Rajbhandari-Thapa, PhD, and Marsha Davis, PhD

Objectives. To evaluate the statewide implementation of childhood fitness assessment and reporting in Georgia.

Methods. We collected survey data from 1683 (919 valid responses from a random-digit-dialed survey and 764 valid responses from a Qualtrics panel) parents of public school students in Georgia in 2018.

Results. Most parents reported that their child participated in fitness assessments at school, yet only 31% reported receiving results. If a child was identified as needing improvement, parents were significantly more likely to change the diet and exercise of both the child and the family.

Conclusions. A state-level mandatory fitness assessment for children may be successful in state-level surveillance of fitness levels; parental awareness of the policy, receipt of the fitness assessment information, and action on receiving the screening information require more efforts in implementation. (*Am J Public Health.* 2020;110:1564–1566. doi:10.2105/AJPH.2020.305834)

Childhood obesity remains a serious and costly public health concern in the United States, with a prevalence of 18.5% among those younger than 20 years.[1] The prevalence of obesity among middle and high school students in the state of Georgia is the eighth highest in the nation. As a response to the national epidemic on childhood obesity, the Centers for Disease Control and Prevention recommended that fitness assessments be used as screening tools in schools.[2] In addition to effects on childhood obesity, physical fitness has effects on academic performance and later health outcomes. Childhood obesity is complex, and many social, socioeconomic, and cultural factors play a role. As such, school-based policy alone does not provide a solution; nevertheless, it has the potential to touch millions of students each day to address childhood obesity.

POLICY INTERVENTION

To combat the childhood obesity epidemic in Georgia, the state legislature passed the Student Health and Physical Education (SHAPE) Act in 2009. This act requires each local school system to conduct an annual fitness assessment for students in grades 1 through 12 during a physical education course.[3] The fitness assessment is based on the FitnessGram, which is a standardized tool used to assess health-related fitness, including aerobic capacity (PACER test, 1-mile walk and run), muscular strength, endurance, flexibility, and body composition (height and weight measurement for body mass index [BMI]).[4] Several US states require BMI screening, with considerable variability in policy implementation, assessment protocols, and reporting.[5] In Georgia, the SHAPE Act requires that each school report (1) the individual FitnessGram results to the parent or guardian of each student, including the child's fitness zone (green = healthy; yellow or red = needs improvement); and (2) the aggregate FitnessGram results to the State Board of Education. With this approach, the policy is designed to monitor physical fitness to aid in describing fitness trends (surveillance) and to use individual reporting to help increase parents' awareness and involvement in their child's health.[2] Figure A (available as a supplement to the online version of this article at http://www.ajph.org) outlines the implementation of the SHAPE Act.

We evaluated the SHAPE Act based on 4 attributes of policy implementation: (1) parental awareness of the policy, (2) parental awareness of the child's assessment results, (3) use of results for modifying behavior and seeking medical care, and (4) parental perception of BMI screening and fitness assessment in schools.

METHODS

We evaluated implementation of the SHAPE Act through surveys that included questions on awareness of the act and FitnessGram activities; changes in the family's or child's diet or physical activity or use of medical care based on assessment results (as suggested by the information provided in the FitnessGram); and perceptions of school-based BMI screening and fitness assessments. Nearly 931 000 students were enrolled in elementary and middle schools across Georgia

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This article was accepted June 11, 2020.
doi: 10.2105/AJPH.2020.305834

Part 3: Launching new Research Institutes at IUI

- Convergent Bioscience and Technology Institute (CBATI)
- Institute for Human Health and Wellbeing (H2W)

Part 3 (cont.): Launching Research Consortia at IUI

- AI
- Informatics
- Community-Engaged Research Impacting Health I
- Sustainability
- Health Economics/Economic Evaluation

Part 3 (cont.): Health Economics Consortium

- Providing consulting services for internal stakeholders (Aim 3)
- Building collaborative and long-term relationships with industry partners
- Measuring community-level, *public health*, economic impacts of investments in healthcare

Thank you! Questions?

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BRING ON TOMORROW

Poll #3

- Do you think that the use of cost-effectiveness analysis to inform health policy decisions is changing?
  - No change
  - Yes, it is increasing
  - Yes, it is decreasing

Poll #4

- Do you think that cost-effectiveness analysis (CEA) should be should be used more or less to inform health policy decisions in your country?
  - Use of CEA is about right
  - CEA should be used more
  - CEA should be used less
  - Don’t know

Questions and Discussion

Poll – word cloud

- Think about a specific person that is about 1-3 levels higher than you are in your work setting. What leadership qualities do you most admire about that person?

Questions and Discussion

Continue the Conversation…

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Meet, network, and continue the conversation:

- Tuesday, May 7
- 6:00PM–7:00PM
- Exhibit Hall at the ISPOR Booth

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