



# Preferences in Big P policy

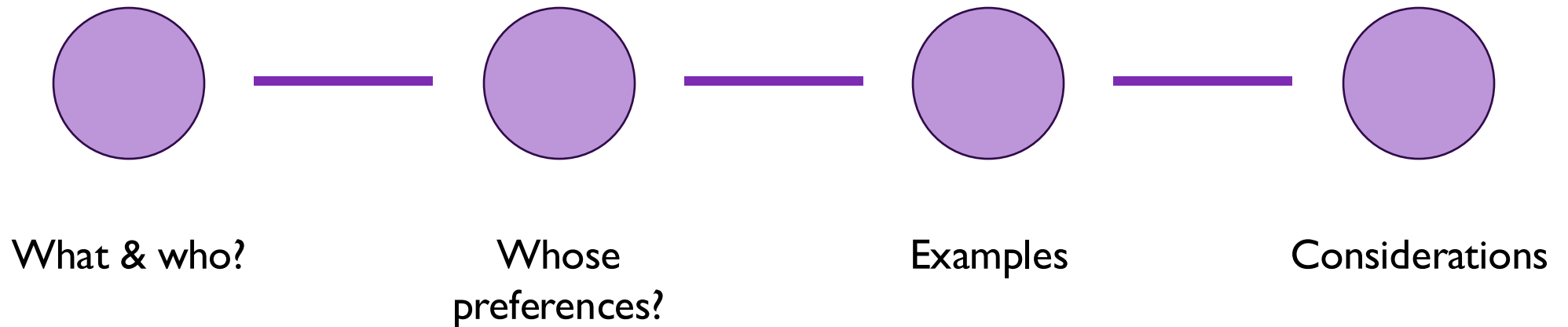
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# Goals for today



*Key collaborators on thoughts & projects presented here:* Davene Wright, Kristen Hassmiller Lich, Doug Levy, Karen Emmons, Jamie Chriqui, Jen Cruz, Stephanie Mazzucca-Ragan, and Alyssa Van Groningen

# Policy is formal & legal

“Big P” public policies are **formal** decisions made by federal, state, and local governments to act (or not to act)

Laws/legislation, ordinances, rules and regulations, executive orders, administrative procedures, and court decisions that **carry the force of law**

# Who are these people?

## Legislative

Senators, representatives

State senators,  
representatives

School boards  
County commissioner

## Executive

FDA commissioner  
CDC director

State director of HHS  
Program managers

Superintendent

## Judicial

Supreme Court

State Supreme Court

Local courts

# What do they care about?

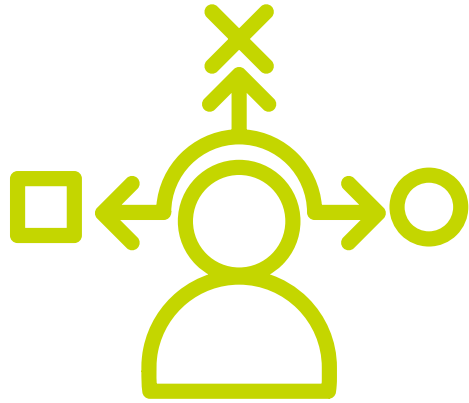
Priorities and preferences depend on policymaker, content area, and decision objective.

## Recent US work:

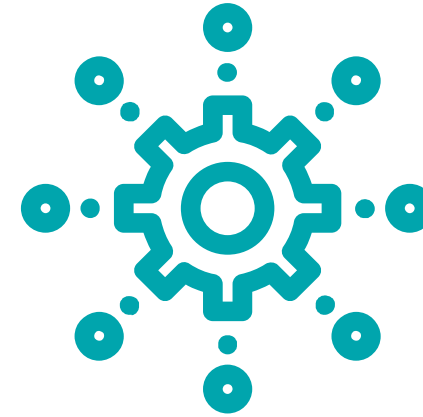
- Tobacco control policy choice (state executive branch) Smith et al., here at SMDM!
- Ethical issues about HIV surveillance methods (state practitioners) Schuster et al., 2024
- Behavioral health research dissemination (state agency officials) Purtle et al., 2020
- Dissemination about cancer (state legislators, staff, bureaucrats) Brownson et al., 2011

Overlaps with HTA – both care about public preferences, and HTA information impacts policy

# Why do we care?



**Develop decision support resources or tools** to help policymakers make decisions that align with their preferences and needs



**Target our research questions & communications** to important decision components, like increasing public support or providing evidence of effects

# Schuster, 2024

Who: "...PHPs from U.S. public health departments who are:

1. leaders with oversight of HIV cluster detection and response programs that include molecular cluster detection, and
2. staff members responsible for implementing HIV molecular cluster detection and/or response."

What: prioritization of 11 ethical issues around HIV molecular epidemiology using best-worst scaling

Please choose the one issue that is **most concerning** and then the one issue that is **least concerning** regarding the use of HIV ME for research or public health in the United States.

Most concerning		Least concerning
<input type="radio"/>	Limited evidence of benefits	<input type="radio"/>
<input type="radio"/>	Infer directionality of HIV transmission	<input type="radio"/>
<input type="radio"/>	Lack of an opt-out option	<input type="radio"/>
<input type="radio"/>	Increase risk of harm towards individuals	<input type="radio"/>
<input type="radio"/>	Re-use of data collected for clinical purposes	<input type="radio"/>

**Fig. 1** Example BWS choice task

	Stratified model importance scores <sup>b</sup>	
	Researchers (n = 29)	Public health (n = 28)
Risk of legal prosecution	15.79	9.35
Group stigma	18.81	23.58
Individual harm	13.27	12.49
Infer source	11.98	14.45
Lack of disclosure	6.39	7.17
Limited evidence	4.38	5.01
Infer directionality	8.17	8.90
Lack of consent	8.18	7.12
Lack of opt-out	6.89	5.83
Data re-use	3.36	4.10
Limited Resources	2.77	2.00



# What matters to state tobacco control practitioners when prioritizing tobacco policy?

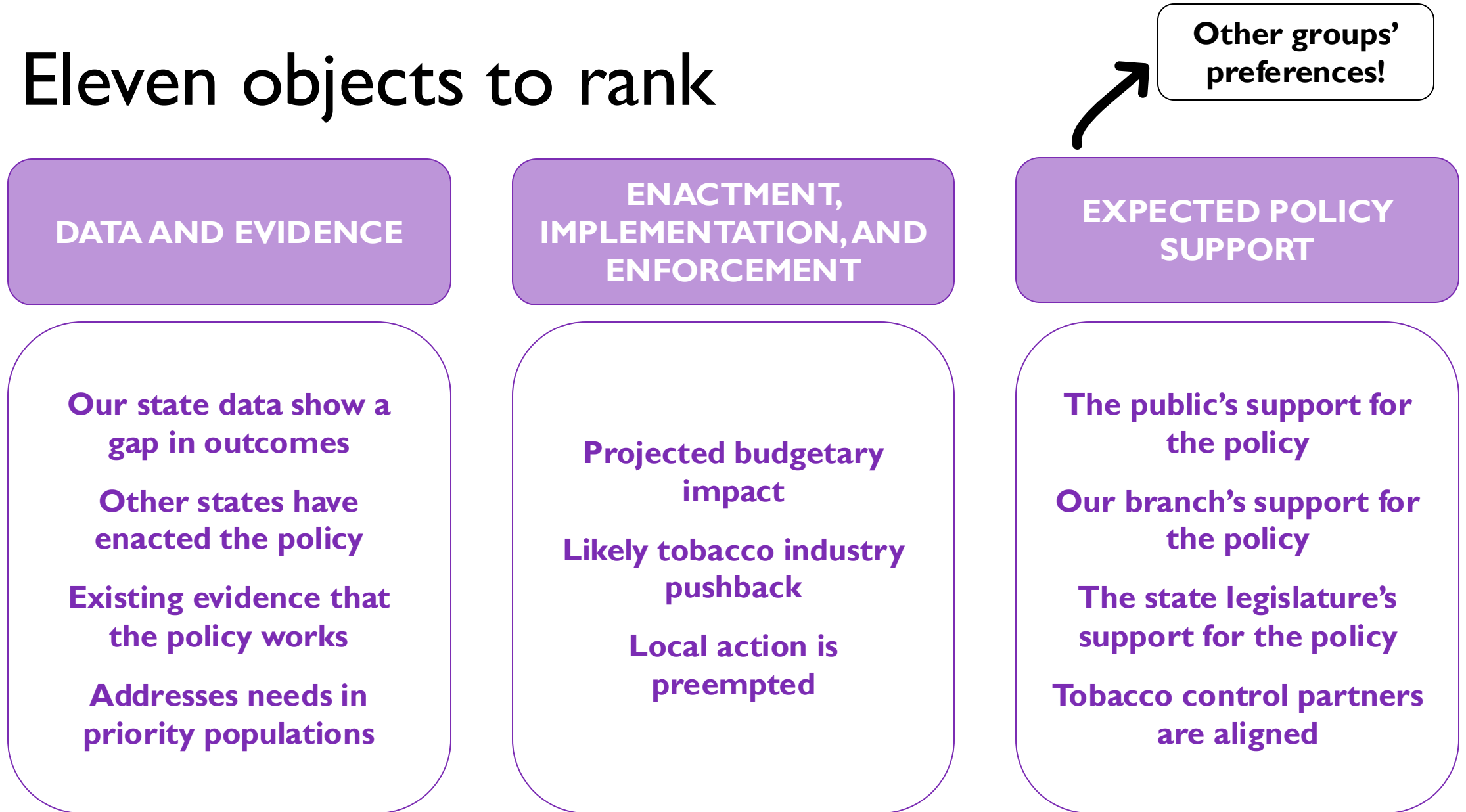
Qualitative interviews

Advisory group

Ongoing best-worst scaling survey



# Eleven objects to rank



1. Which of these things are the **most** important and **least** important to you when prioritizing policies?

Most  
important  
(select one)

Least  
important  
(select one)

☐

Our branch's support for the policy

☐
☐

Local policy action is preempted

☐
☐

Our state data show a gap in outcomes

☐
☐

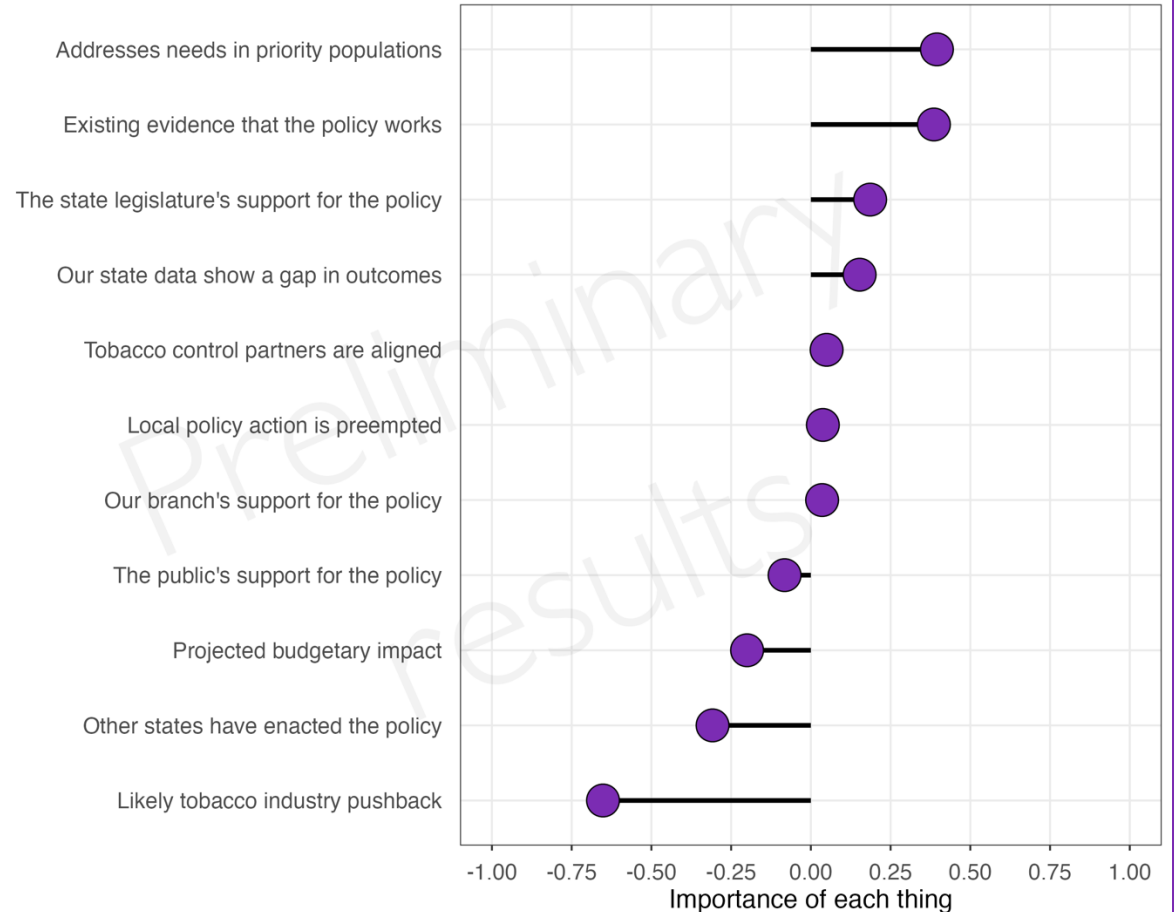
Tobacco control partners are aligned

☐
☐

Likely tobacco industry pushback

☐

# What is important?



\* Preliminary findings, please do not disseminate\*

# Considerations for this work

“Policymakers” language can be squishy – big P policymakers, or advisory councils, organizational policy, something else? Define!

Levels of preferences – their own, their coworkers, their bosses’, other branches of government, their constituents, advocacy/interest groups, and outside/financial interests. Complex!

Constraints of their role – methods, participation

- Sample sizes and survey length
- Confidentiality

Learn from other areas – education, energy, transportation



# Polymakers have major decision-making power and impact health – we should understand and measure their preferences

Similarities with HTA perspective?

What polymakers are most interesting to you?

Lessons from your own work?



Scan to connect & see  
more about this work!

# Key references

Chriqui, Jamie F, Yuka Asada, Natalie Riva Smith, Aimee Kroll-Desrosiers, and Stephenie C Lemon. "Advancing the Science of Policy Implementation: A Call to Action for the Implementation Science Field." *Translational Behavioral Medicine*, June 24, 2023, ibad034. <https://doi.org/10.1093/tbm/ibad034>.

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Purtle, Jonathan, Félice Lê-Scherban, Katherine L. Nelson, Paul T. Shattuck, Enola K. Proctor, and Ross C. Brownson. "State Mental Health Agency Officials' Preferences for and Sources of Behavioral Health Research." *Psychological Services*, June 13, 2019. <https://doi.org/10.1037/ser0000364>.

Brownson, Ross C., Elizabeth A. Dodson, Katherine A. Stamatakis, Christopher M. Casey, Michael B. Elliott, Douglas A. Luke, Christopher G. Wintrobe, and Matthew W. Kreuter. "Communicating Evidence-Based Information on Cancer Prevention to State-Level Policy Makers." *Journal of the National Cancer Institute* 103, no. 4 (February 16, 2011): 306–16. <https://doi.org/10.1093/jnci/djq529>