

To Be or Not to Be: Accredited

A Menu of Incentives to Promote Public Health Accreditation

By Lee Thielen

The 2011 launch of voluntary accreditation of public health agencies by the Public Health Accreditation Board (PHAB) has provided a new and dynamic system for public health agency improvement. This system is new for public health agencies, requiring adherence to national standards focused on public health infrastructure, prerequisites that need to be met, and a fee schedule that must be paid. As with any accreditation program, time and resources are needed for any agency to prepare, apply, and achieve accreditation.

Incentives can serve one of two purposes related to public health accreditation. There are those that support or create a clear benefit of accreditation for the organization (e.g., recognition as a quality agency, adherence to law or regulations, etc.) and there are those that remove barriers preventing an organization from seeking accreditation (e.g., funding and/or technical expertise to complete the application process).

Incentives That States Can Use to Support Local Jurisdictions

1. State Developed Standards Equal PHAB Standards. States that adopt PHAB standards as state standards provide a strong incentive for preparation for national accreditation. North Carolina, Missouri, Michigan, Iowa, and Washington have adopted public health agency standards for their local health departments or their state agency, many of which informed the development of PHAB standards. Colorado is in the process of adopting state standards for local health departments.

Washington State has incorporated the PHAB standards into the state standards. They also have a Basic Set of Standards that is a subset of the PHAB standards. Colorado is considering the PHAB standards as they develop the Colorado State Standards. Michigan has incorporated the PHAB standards from Domain 9 into their voluntary Accreditation Quality Improvement Supplement. If that Standard is met, the Michigan local jurisdiction

can receive Accreditation with Commendation. Iowa has kept their state standards, but aligns them with the PHAB standards.

2. PHAB Accreditation Counts for State Accreditation. States with mandatory state accreditation, including North Carolina and Michigan, could offer a very strong incentive for national accreditation if PHAB accreditation is accepted in lieu of or as equivalent to state accreditation.

3. Direct Financial Support to Prepare for Accreditation. Montana had a time limited grant program through HB 173 to support local health departments to prepare for accreditation. Seven grantees received \$25,000 for 2 years to complete the prerequisites for accreditation. Those agencies are now in a better position to apply for accreditation if they choose to do so. North Carolina has historically provided financial support to local health departments to undergo state public health accreditation. Arizona has given 13 of the 15 local health departments grants of \$45,000 each to develop the prerequisites for accreditation. This is funded with a combination of Preventive Health Block and NPHII funding. Colorado has funded some of the local jurisdictions to work on community health assessments. Florida has given \$3000 to local health departments for systems assessments and additional funding of \$17,000 to develop such initiatives as prerequisites or workforce development plans.

New York State provides \$250 million to its local health departments through the General Public Health Work Program, also called Article 6. Officials in NY are considering aligning requirements for this program with PHAB accreditation standards and incorporating incentives for accreditation. The cost of applying for accreditation is currently an approved expense in this program.

4. Training and Technical Assistance. Major barriers to seeking PHAB accreditation include a lack of capacity at the state and local level, especially to complete the health assessments, health improvement plans, and the strategic plans that are required prior to the application for PHAB accreditation. In addition, public health has historically been weak in the use of and the knowledge of quality improvement techniques and processes. NPHII funding has been used in 31 states and one Tribe to provide support for local jurisdictions in these areas. Topics covered include:

- 1) Mobilizing for Action Through Planning and Partnerships (MAPP) training
- 2) Performance management training
- 3) Quality improvement training
- 4) Performance improvement technical assistance
- 5) Dashboard technical assistance
- 6) Training on the Guide to Community Preventive Services
- 7) Protocols for access to data
- 8) Community Health Assessment training and technical assistance
- 9) Accreditation preparation training
- 10) Strategic planning training and technical assistance
- 11) Community Health Improvement training and technical assistance

- 12) Health informatics technical assistance
- 13) Sustainable funding technical assistance
- 14) Results-based accountability methods training
- 15) Public health workforce competencies training and technical assistance
- 16) Baseline assessment technical assistance
- 17) Collection and dissemination of best practices
- 18) Gap analysis based on PHAB measures technical assistance
- 19) Shared services (regional services) technical assistance
- 20) Project Management
- 21) Logic Models for Public Health Programs
- 22) QI Agency -Wide Culture of Improvement
- 23) Quality Planning
- 24) Facilitation
- 25) Organizational Change.

A training that has been suggested by local health departments is the development of a mock accreditation site visit. This was done in Kentucky by the Three Rivers Health District and has been requested by other local health departments.

Washington State has created an unusual model by funding three Public Health Performance Management Centers for Excellence. One is at the state health agency. The others are at the Tacoma-Pierce and the Spokane Regional Health Departments. These centers, funded with \$60,000 a year, are providing technical assistance and training across the state, serving all of the local health departments.

Some key informants would find the availability of materials, such as brochures or PowerPoint presentations designed to communicate with elected officials, as helpful tools.

5. Leading by Example. Directors of local health departments addressed a recurrent theme when asked how the state could help with preparation for accreditation. That theme was that the state needs to set a good example. Some stated that the state health agency needed to “get their own house in order” to be able to show that quality improvement and preparation for accreditation are important and doable. Many states are using their resources to do just that, focusing internally at this stage on the path to accreditation and quality improvement with state staff training and accreditation coordination as a high priority. California is setting an example for that state with the state health agency leading the way for accreditation and quality improvement both internally and with local health departments.

6. Collaboration and Peer Support. Whether called Learning Collaboratives, Learning Circles or Accreditation Teams, peer collaboration and support are powerful incentives. They help the staff of local health departments by providing a safe environment in which to learn, ask questions, look for examples of good practices, and provide encouragement and peer counseling when the challenges look hard. State health agencies can encourage these teams through funding, staff support, or by participation. These teams do not

necessarily need resources to work, although the use of resources to support trainers or consultants adds a robust capacity to the teams.

The Public Health Accreditation Council of Texas (PHACT) was created to work through the question of whether the state should develop its own system or support PHAB accreditation. Initiated by local health departments, PHACT members include Texas Association of Local Health Officials (TALHO), the Texas Health Institute, other health organizations, academia, and the state health department. After much consideration and work with the PHAB staff, PHACT intends to support national accreditation and not create a separate system. In addition, Texas CDC NPHII Grantees (Austin, Dallas, Houston and San Antonio) work together sharing resources, information and progress on quality improvement and performance management.

Kentucky's Accreditation Coordinators Workgroup includes accreditation coordinators from 30 out of 58 local health departments who meet monthly to further their work on the prerequisites, documentation, facilitations, and QI efforts for PHAB. They share templates, QI plans, structure concepts, and documentation strategies. They also facilitate each other's community meetings. When asked how important this group was to the participants on a scale of 1-10, all those interviewed said it was a 10. One district health department, Three Rivers, set up a mock two-day site review from which all participants benefited. Although these efforts are primarily locally driven, the state is a participant and is appreciated for sharing its QI work and bringing specialists to the meetings when needed. The meetings are managed and supported by the local health departments, which is a strength of the process. The state offers a positive model through its own team called ART or Accreditation Readiness Team.

Florida has supported Accreditation Preparation Learning Communities with 25 counties in 4 collaboratives. These learning communities started during the RWJF funded Multi-State Learning Collaborative and have continued to provide ways to share expertise, knowledge and data.

6. Financial Incentives. The states can use either federal or state funding to provide financial incentives. These can be for specific purposes, such as paying for the PHAB accreditation fees, paying for outside consultants, supporting the cost of an Accreditation Coordinator, or helping pay the costs for prerequisites. For example, Washington State has given six \$10,000 mini-grants to local health departments for performance management.

7. Linking State Funding to Prerequisites. A number of states required progress on community assessments, health improvement plans, or strategic plans to receive state funding for the local capacity grants. In some states, this has been a practice in place for many years. In others, such as Washington State, this is a new requirement to encourage preparation for accreditation. Illinois has had a long-standing requirement for completion of an improvement plan called IPlan (Illinois Project for Local Assessment of Needs).

8. Funding of Accreditation Coordinators. Oklahoma has invested both state and federal money into supporting a cadre of accreditation coordinators at the district level. This centralized state has a goal of all county health departments becoming accredited. They are supporting their counties in a very tangible way with accreditation coordinators to assist every county.

9. Importance of Building Strong Relationships. State health agencies that have a history and philosophy of including local jurisdictions in planning and funding decisions are better able to leverage those relationships to improve the entire public health system. Staff from Arizona, for example, state that without a strong and trusting relationship, improvements could not be made.

10. Fear, Trepidation, and Conditional Funding. Although not freely discussed, some local and state officials refer to their motivation to move toward accreditation as being based on a fear of being left behind in future funding opportunities, especially from CDC and the state health agency. Most public health officials share the concept of the “inevitability” of accreditation. Many directors do not want their agency to be unaccredited when accreditation becomes a norm. Access to a pool of funds that is available only to accredited agencies would be a benefit that is very concrete. The belief that targeted funding will happen is ubiquitous. Actually using this incentive may be less controversial than previously thought, since it is an oft- held prediction by many in the field.

11. Use of the Law and Regulations to Support Prerequisites. State laws and regulations that mandate health assessments, health improvement plans and/or strategic plans for state and/or local jurisdictions take the guesswork out of when and if these key public health strategies will occur. Incorporating some or all of the prerequisites into law or regulation is a way to raise the feasibility of public health agencies being ready for accreditation.

Legal mandates for accreditation or completion of the prerequisites for accreditation are found in many states. A recent study by the Colorado Association of Local Public Health Officials, funded by the Robert Wood Johnson Foundation, identified these mandates. Legal mandates constitute a very powerful incentive. Two states, Vermont and Maine, specifically refer to national accreditation in their laws. Vermont, a centralized state, requires that the department of health, “Seek accreditation through the Public Health Accreditation Board,” (Sec. 26. 18 VS. A.5). Maine addressed accreditation with a law that states, “The Statewide Coordinating Council for Public Health shall report annually to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the Governor’s office on progress made toward achieving and maintaining accreditation of the state public health system and on district-wide and statewide streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of essential public health services. “ (22 MRSA 412)

Twenty - four states have some kind of a mandate regarding one or more of the PHAB prerequisites, most of which were in place prior to PHAB’s creation. Some of these

mandates are in law, but others are found in regulations, executive orders, contracts, or other legal tools. In some cases, funding from the state to the local jurisdictions is tied to the completion of one or more of the prerequisites for PHAB accreditation.

12. Data Assistance for Assessments and Planning. Some state health agencies have allocated staff and resources to support local health departments in their community health assessments and their public health improvement plans. Colorado, using NPHII funding, has a local public health data specialist in the Health Statistics Section who is dedicated to providing local data support. The state health agency has developed a web-based data system with over 200 county level indicators for local health departments. In addition, the state provides both training and technical support to the local staff. Florida and Minnesota have a history of supporting their public health systems with such tools as dashboards and data interpretation guides.

How CDC Can Incentivize the States

The role of the federal government is a very important factor in accreditation acceptance and engagement. As noted above, the NPHII funding has been a powerful tool to improve the performance of public health agencies and systems. There are some additional possibilities that could move agencies forward on the path to accreditation. These include:

1. Streamline the process for accredited agencies to apply for federal funding. This can be done by identifying steps that accredited agencies could skip due to an assumption that as an accredited agency, certain requirements are in place.
2. Reduce the reporting requirements for accredited agencies.
3. Provide “extra credit” for applications for funding from accredited agencies.
4. Provide increased flexibility in the use of programmatic funds for accredited agencies.
5. Spread the cost of accreditation over the federal programs. One important barrier reduction has already been made. CDC has determined that federal CDC program grant funding can be apportioned to cover costs of accreditation. Accreditation fees are an allowable expense in CDC grant program funding. This incentive will be stronger if the Health Resources and Services Administration (HRSA) and the Department of Agriculture also agree to that policy. The local health departments do not necessarily know about this opportunity to use program funding for accreditation. CDC may need to publicize that directive so that both state and local staff understand the opportunity. States may not be sharing that information with local health departments regarding pass-through CDC funding.
6. Messaging to grantees. The responsibility for the state health agency to encourage and assist all public health agencies in their state through NPHII and other federal funding could be clearer. This could be reinforced through the Performance Improvement Manager (PIM) job descriptions on the CDC website, the language in the grant guidance,

and through the goals in the grant applications. Currently, the language is fairly silent on the expectation that the state agency that receives the funding will assist the local health jurisdictions. An even bolder approach would require concurrence by the local health officials in the grant application that the state submits. Such concurrence is required for public health preparedness funding. CDC could consider a general practice of incorporating, “Public Health System Improvement in All Policies”.

7. Providing information and success stories. CDC is in a unique position to tell the stories of successes of accreditation and performance improvement. They can do this directly or through the associations they support with cooperative agreements. For example, Oklahoma has a compelling success story regarding how the pursuit of accreditation has improved their services. Stories such as these can be shared to inspire others of the potential benefits of accreditation.

8. Maintaining predictable funding for accreditation. The use of NPHII funding is seen as key to the ability of states to engage in the arena of performance improvement and preparation for accreditation. In addition, the support to the major associations for technical assistance and training of their constituents has been key to the preparation of the field for accreditation. Providing CDC support through the Accreditation Support Initiatives to large cities, institutes, state affiliates, etc. helps move the field forward. Such funding can be used to support preparation work and partially support PHAB fees. CDC and HRSA can use influence to stress to the Public Health Training Centers at the schools of public health their responsibility in supporting accreditation and quality improvement for the practice community.

9. Targeting funding. Soon there will be a pool of public health agencies that are accredited. At a point of critical mass, a pool of funding could be available only to accredited agencies. This is similar to the requirement for many federal grants that are only available to accredited schools of public health.

Other Players in Incentives

There are other players who can help and are helping with incentives for accreditation of public health agencies. These include public health institutes, academia, state and national associations and private foundations.

1. Public health institutes and academia are well organized to provide training and technical assistance. The Public Health Training Centers in schools of public health may embrace a mission to support agencies on their path to accreditation. Both types of organizations may be well suited to support collaborative approaches in health assessment and health improvement plan completion.

2. National associations, with funding from the CDC and RWJF, have been offering grants, technical assistance and extensive training to their members. They are well suited to being credible sources for expertise and tools.

3. State associations are close to their members. They could be excellent conduits for technical assistance, training, and support of peer accreditation teams and learning circles. The state affiliates of APHA and NACCHO, for example, have shown their ability to support members in preparation for accreditation.

Other Drivers for Accreditation

1. PHAB could strengthen the state standards related to the responsibility of the state agency to support the improvement of the public health system, including local jurisdictions.

2. Private funding through major foundations, especially the Robert Wood Johnson Foundation, has been and will continue to be important to removal of barriers to accreditation.

3. Support for public health agency accreditation by well-positioned associations or organizations outside of public health would be a strong incentive. Support for accreditation by the National Governors' Association, the National Association of Counties, the Institute of Medicine, the National Conference of State Legislatures or similar organizations would be a powerful incentive.