

Rural Public Health Agency Accreditation Final Report

SUBMITTED TO:

THE NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES
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AND

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RURAL HEALTH ANALYSIS

This report was written by Michael Meit, MA, MPH, Karen Harris, MPH, Jessica Bushar, Bhumika Piya, and Maria Molfino. We gratefully acknowledge the National Network of Public Health Institutes and the Centers for Disease Control and Prevention for their support in conducting this project. We are also grateful to all of the local and state health officials who contributed their time and energy to the research study, and to the Association of State and Territorial Health Officials and the National Association of County and City Health Officials for their assistance in completing this project. Finally, we want to recognize and acknowledge our former colleague, Benjamin Hamlin, MPH, who provided initial staff support to this study.

This study was conducted under contract to the National Network of Public Health Institutes, with funding from the Centers for Disease Control and Prevention. The conclusions and opinions expressed in this report are the authors' alone; no endorsement by NORC, NNPPI, CDC, or other sources of information is intended or should be inferred.

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1. Executive Summary

The National Network of Public Health Institutes (NNPHI), with funding from the Centers for Disease Control and Prevention, contracted with the NORC Walsh Center for Rural Health Analysis to study barriers and opportunities to public health agency accreditation among state and local health departments serving rural jurisdictions. The purpose of this study was to enhance understanding of how public health infrastructure may dictate rural health departments' approaches to seeking accreditation. This research was comprised of three phases: 1) a literature review, 2) a half-day panel discussion with eleven representatives of local health departments (LHDs) located in rural areas, and 3) semi-structured, key informant interviews with eight representatives of state health departments with rural areas not served by local governmental public health.

The literature review provided background and context for the two research components of the study, providing a brief history of accreditation efforts, current trends, and the documented experiences of health departments in pursuing accreditation. Wherever possible, literature that included rural health departments was referenced. Where there were gaps in knowledge, hospital and health plan accreditation studies that included rural facilities were referenced, as findings may be at least somewhat generalizable to public health.

The panel discussion brought together eleven LHD representatives from rural areas to gain insights into why LHDs serving rural areas have sought or will seek accreditation; how those agencies are likely to approach accreditation (e.g., through regional collaboration, consolidation, etc.); barriers to accreditation that they may face; and strategies for accreditation they are likely to employ. A call for panelists was distributed through the National Association of County and City Health Officials (NACCHO) to seek LHD representatives interested in the topic of accreditation. In order to have a broad mix of knowledge and attitudes toward LHD accreditation, a pre-panel questionnaire was used to identify participants with diverse backgrounds in terms of their familiarity and direct experience with accreditation. Further, analyses were conducted using RUCA Codes to ensure a broad range of degree of rurality among participants, ranging from "Weakly Tied to an Urban Core" to "Isolated Rural." NORC worked closely with the Centers for Disease Control and Prevention (CDC) and NNPHI to develop structured protocols for the expert panel discussion in order to highlight salient points related to rural agency accreditation.

Semi-structured interviews with current and former leaders from state health departments were conducted to identify strategies and challenges to ensuring access to public health services in communities not served by LHDs, and implications for state level accreditation. The *State Public Health Law Assessment Report* by Lawrence Gostin and James Hodge and the Public Health Foundation's *Survey of Performance Management Practice Systems in States* were used to generate a preliminary list of states with centralized and mixed infrastructures. Discussions were then held with CDC, NNPHI, and the Association of State and Territorial Health Officials (ASTHO) to select a final sampling frame based on knowledge of state public health systems in which at least some rural communities are not under the jurisdictional authority of a local health department or localized unit of the state health department. States ultimately included in the study were Maine, New Hampshire, New Mexico, Pennsylvania, South Dakota, Texas, Utah and Wyoming.

Finding 1: Efforts to develop consistent standards present unique challenges for rural LHDs.

Rural public health systems differ from urban systems in terms of workforce capacities, infrastructure, diversity of population served, and funding, among others. LHD panelists and state public health leaders both noted that the organization of the state's public health system can influence whether or not an LHD has the motivation and capacity to meet accreditation standards. The potential benefits of voluntary accreditation programs may be more difficult to foresee in rural areas given the wide variance in rural public health infrastructure and the kinds of services delivered in those areas. Further, study participants noted that public health infrastructure in much of rural America is weak and it may take more effort and resources for rural LHDs to meet accreditation standards than their urban counterparts.

Finding 2: Accreditation can be a tool to communicate the functions of public health by delineating its responsibilities and clarifying its role to the community and stakeholders.

Educating the public, staff and other stakeholders on what public health is all about is important as the purview and responsibilities of LHDs continue to expand. Accreditation could be used to communicate the benefits of public health to county commissioners, board of health members, governors, and other state and local policy makers in order to leverage and/or sustain funds for public health activities. In addition, accreditation could foster interaction among stakeholders, encouraging collaboration to meet high standards, avoid duplication of efforts within communities, and maximize returns from scarce resources. Given the fragile nature of the rural public health infrastructure and the greater dependence on state and federal pass through resources, these education efforts were deemed even more critical in rural areas.

Finding 3: Improving capacity and quality of services are perceived as key benefits of accreditation.

Both the state officials and LHD representatives agreed that because all agencies would be required to adhere to set standards, accreditation could lead to improved quality of services, while setting a bar for health departments to achieve certain capacities. Some were also optimistic that accreditation would promote uniformity in the quality of services delivered across health departments. Accreditation could further be used to monitor agencies' performance and document outcomes for strategic planning and quality improvement initiatives. Moreover, some suggested that accreditation could enable them to more effectively compete for more grant money from governmental and non-governmental sources. Given the lack of uniformity across public health agencies in general, and rural agencies specifically, efforts to demonstrate consistency in public health services was seen as important to rural health departments.

Finding 4: Inadequate fiscal and human resources were identified as major barriers associated with health department accreditation.

Barriers to accreditation reported among rural LHDs included inadequate staff knowledge of accreditation; lack of formal public health training among LHD staff; shortages of resources; and structural barriers, such as siloed funding streams and fragmented public health system. There was a strong consensus among the panelists and state key informants that lack of adequate funding is the major barrier to seeking accreditation. Panelists and interviewees expressed frustration at the paucity

of grant funds directed to rural agencies, and noted that the limited amount that reaches the local level is often marked for specific conditions or diseases. Inadequate staff knowledge about accreditation was cited as another impediment to rural health departments actively pursuing accreditation. This problem emanates from workforce issues faced by LHDs in general (e.g., lack of public health education), that are often even more prominent in rural areas.

Finding 5: Multi-level or tiered approaches should be considered as potential strategies for implementing a national accreditation system.

Both state and local level participants recognized the disparate nature of public health systems cross the country and suggested flexible, inclusive approaches to accreditation. At the state level a “multi-level” approach to accreditation was envisioned. This approach was seen as having distinct accreditation standards focused on: public health services provided locally, public health services provided at the state level (e.g., centralized management activities), and local public health services provided by the state (to address the issue of SHDs providing services in local jurisdictions not served by LHDs). Alternatively, a few key informants believed that SHDs directly responsible for providing local public health services should not be held to a different standard, but should rather be held to the same standards as LHDs. Similar discussions were also held among LHD participants, who suggested a tiered approach to accreditation. A tiered system would involve applying different standards to LHDs based on the specific services they provide, as opposed to requiring all LHDs to meet one rigid set of standards. It was felt that this could provide a means of creating an inclusive accreditation system, whereby “limited service” LHDs could be accredited only for the services they provide, and not penalized for those that they do not provide.

Finding 6: Educating health department staff and policy makers are key strategies for rural LHD accreditation.

In addition to the core recommendations on implementing accreditation at the national level, participants also provided concrete recommendations for local level implementation. These included educating health department staff about the rationale and benefits of accreditation and demonstrating the value of accreditation to county commissioners and mayors who may otherwise see it as an unfunded mandate. Participants noted that, particularly in rural health departments, staff are not educated in public health and are therefore less likely to understand the benefits of accreditation. Local policy makers are likely to have an even more limited understanding of public health and further, have the responsibility of balancing multiple community needs. This may limit the level of priority placed on public health among policy makers, who may otherwise see issues such as accreditation as an added burden. Educating both staff and policy makers regarding the potential value (monetary and otherwise) of accreditation is critical in implementing efforts in rural communities.

2. Introduction

Public health systems in rural areas differ from those in urban areas in terms of scope of services and functions, in part due to differences in the level of resources available and in part based on geographic isolation and the corresponding size of the population served. How these distinctly rural features affect state-level public health governance, state support for local health departments, and local health department functions, is not well understood. Many ‘public health’ functions are conducted, at least in part, by hospitals, private practice physicians, and community-based organizations, as well as a variety of entities that are not focused strictly on health. Moreover, many rural areas have no local governmental public health infrastructure at all.¹ In these instances, the state health department bears responsibility for the provision of local public health services, which are provided either directly through units of the state health department, or contracted to other local providers such as hospitals and non-governmental organizations.

The National Network of Public Health Institutes (NNPHI), with funding from the Centers for Disease Control and Prevention, contracted with the NORC Walsh Center for Rural Health Analysis to study the effects of rurality on public health agency accreditation. The purpose of this study was to enhance understanding of how public health infrastructure may dictate rural health departments’ approaches to seeking accreditation. Specifically, NORC studied the perceived barriers and opportunities to public health agency accreditation among state and local health departments serving rural jurisdictions, and recommended strategies for moving forward. This research was comprised of three phases: 1) a literature review, 2) a half-day panel discussion with eleven representatives of local health departments (LHDs) located in rural areas, and 3) semi-structured, key informant interviews with eight representatives of state health departments with rural areas not served by local governmental public health.

This report is organized around four major sections. In section III, we present a review of the current literature on public health agency accreditation, focusing on its implications for rural health departments. The section covers the history of public health accreditation efforts, followed by an overview of motivations and barriers faced by rural agencies in seeking accreditation. Section IV presents findings from the expert panel discussion which brought together leaders from rural LHDs. In section V, we present an analysis of state level key informant interviews describing attitudes and experiences of state health officials related to accreditation. Finally, section VI summarizes the major findings and their implications for the entire study.

¹ University of Pittsburgh Center for Rural Health Practice. *Bridging the Health Divide: The Rural Public Health Research Agenda*. Bradford, PA: University of Pittsburgh at Bradford; 2004; 7-10. Available at: <http://www.upb.pitt.edu/crhp/Bridging%20the%20Health%20Divide.pdf>.

3. Literature Review

Accreditation is defined as “the periodic issuance of credentials or endorsements to organizations that meet a specified set of performance standards.”² The increase in accreditation programs in recent decades can be attributed to external and internal pressures to improve the overall value and quality of services in an industry.³ In particular, accreditation programs have become a common way for health and social services programs to establish accountability to the public and to other stakeholders.

In recent years, accreditation has been identified as a potential strategy for strengthening the public health system. A comprehensive national accreditation effort may help reduce variation in the adequacy of public health services both across and within states. Given the unique nature of public health systems in rural jurisdictions, the implications of voluntary accreditation programs in these communities calls for a close and contextually sensitive examination. As part of this literature review we provide a brief history of public health accreditation efforts, followed by an overview of motivations and barriers to accreditation among rural agencies. Wherever possible, data and studies including rural public health agencies are referenced; where data and studies have not been conducted, hospital and health plan accreditation studies that included rural facilities are referenced as findings may be generalizable to public health.

History. Surprisingly, the history of public health agency accreditation efforts dates as far back as the 1920s, when the American Public Health Association’s (APHA) Committee on Administrative Practice developed and released its *Appraisal Form for City Health Work*. The main objective of this effort, as noted by the Committee, was the standardization of health practice:

“The aim...has been to devise a brief Appraisal Form which would yield a reasonably accurate picture of health services actually performed in a city as evidenced by certain typical sample activities. It was to be based not on money expended or personnel employed, which indicate resources rather than performance. Nor was it to be based on mortality rates, which are affected by so many racial and industrial factors as to make comparisons between various cities so frequently misleading. The idea was rather to measure the immediate results attained—such as statistics properly obtained and analyzed, vaccinations performed, infants in attendance at instructive clinics...with the confidence that such immediate results would inevitably lead on to the ultimate end of all public health work, the conservation of human life and efficiency.”⁴

² Novick LF, Mays GP, eds. Public health administration: principles for population-based management. Gaithersburg, MD: Aspen Publishers; 2001; p. 765.

³ Mays GP. Can accreditation work in public health? Lessons from other service industries. http://www.rwjf.org/files/publications/other/publichealth_Maysummary.pdf. Robert Wood Johnson Foundation working paper. Published November 30, 2004.

⁴ Appraisal Form for City Health work. American Public Health Association Committee on Administrative Practice. First Edition, March 1925; p. 1.

As notable as this is, even more surprisingly, the APHA's Committee on Administrative Practice developed a *rural* version of the appraisal form in 1927, just as rural county health departments were beginning to emerge in the United States. The *Appraisal Form for Rural Health Work* was developed to both recognize the "high standard of accomplishment" among counties with "well organized departments" and to "point out to other communities their totally inadequate or neglected health department rather than compromising on a dead level of mediocrity."⁵ Throughout the 1920s and 1930s, public health reports and evaluations referenced the APHA appraisals extensively. In a 1931 evaluation of one of the nation's first rural health departments for example, in Cattaraugus County, New York, the APHA appraisal was used both to measure progress in developing local public health capacities (with total appraisal scores rising from 41 out of 100 in 1923 to 81 out of 100 in 1929), and to benchmark the county against other similar communities across the United States (appraisal scores were compared to other county health departments in TN, CA, GA, OR, and NJ).⁶

More recently, interest in accreditation was renewed by the Institute of Medicine's (IOM) 1988 report entitled *The Future of Public Health*, which raised concern about public health's infrastructure and future capacities.⁷ Fifteen years later, the IOM released *The Future of Public Health in the 21st Century*, which highlighted ongoing concerns related to public health infrastructure and "set the stage for governmental public health entities to become more accountable for what they do."⁸ The report, however, did not directly recommend accreditation as a means to increase public health's accountability, but rather recommended that a national commission begin to consider whether accreditation could indeed strengthen state and local public health agency capacities.⁹ The timing of the IOM report also coincided with the release of the *National Public Health Performance Standards* (NPHPS), which later became adopted as the "gold standard" for many state-level accreditation efforts.¹⁰

In addition to the IOM reports and the establishment of the NPHPS, the National Association of County and City Health Officials (NACCHO), developed an initiative to operationally define a functional local health department (LHD). The intent of this project was to answer some of the more fundamental questions about the role of LHDs, while further laying down the ground work for the accreditation efforts. In 2005, The *Exploring Accreditation Project*, a partnership between the Association of State and Territorial Health Officials (ASTHO) and NACCHO, was launched to formerly explore the desirability and feasibility of such efforts.

Rather than waiting for a national accreditation program, many states have taken the lead in implementing their own state-wide accreditation programs for their LHDs. Although useful models, programs across states are extremely variable, thereby creating additional challenges in developing a uniform national accreditation process. For example, even terminology varies across states, with some states avoiding the term "accreditation" altogether and instead opting for "standards" or

⁵ *Appraisal Form for Rural Health Work: For Experimental Use in Rural Counties, Districts or Other Similar Areas*. American Public Health Association Committee on Administrative Practice. First Edition, January 1927; p. 2.

⁶ C.E.A. Winslow, *Health on the Farm and in the Village: A Review and Evaluation of the Cattaraugus County Health Demonstration with Special Reference to Its Lessons for Other Rural Areas*, Macmillan, 1931.

⁷ Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press; 1988.

⁸ Turnock B, Barnes P. History will be kind. *J Public Management and Practice*. 2007; 13(4), pp. 337-341.

⁹ Institute of Medicine. *The Future of Public's Health in the 21st Century*. Washington, DC: National Academy Press; 2003.

¹⁰ Centers for Disease Control and Prevention. *National Public Health Performance Standards*. Atlanta: Centers for Disease Control and Prevention; 2002.

“certification.” Some accreditation programs are mandatory, while others voluntary; some require review of administrative records, client and community interviews, and submission of performance measures and data, while others do not. Many programs are based on self-assessment, while others rely on third parties to evaluate the outcomes of their accreditation efforts. Local accreditation programs also vary across the frequency of review, levels of accreditation status, performance domains assessed, strength of incentives, evaluation processes, and collection of outcomes data.¹¹

Despite the variance among these state accreditation processes, there is much to be learned from these early adopters. In conjunction with the *Exploring Accreditation Project*, the *Multi State Learning Collaborative on Performance and Capacity Assessment or Accreditation of Public Health Departments* (MLC) is an initiative that is examining efforts in five states (Illinois, Michigan, Missouri, North Carolina, and Washington) implementing state-wide accreditation programs. It is interesting to note that although demographic variables have been collected as part of these state accreditation efforts, there has been little research examining whether variables such as rurality are associated with any benefits or challenges in obtaining accreditation.

While it is important to “learn from those who have gone before,” it is also important to recognize that organizations that seek and obtain accreditation may be meeting accreditation standards more effortlessly than organizations that do not seek accreditation, resulting in a self-selection bias.¹² This self-selection bias may be heightened in rural health departments that have limited resources and capacities in relation to larger or more urban public health agencies. Another potential bias that should be considered is a program effect, whereby organizations that undergo accreditation improve their service quality to meet service standards.¹³

Rural Motivations and Challenges to Seeking Accreditation. It has been generally noted that rural public health systems differ from urban systems with regards to workforce development, emergency preparedness, public health advocacy, infrastructure, diversity of population, and funding, among other issues and concerns.¹⁴ Various demographic, geographic, social, economic, and cultural conditions in rural areas present unique challenges to rural residents and providers alike.¹⁵ Relative to urban communities, rural communities often deal with lower wages, higher unemployment rates, higher numbers of under- or uninsured, lower socioeconomic status, fewer educational opportunities, greater travel distances, lack of public transportation and youth migration that leaves behind an older population with limited support systems.¹⁶ Within this broader context of

¹¹ Beitsch LM; Thielen L, Mays G, et al. The Multi-State Learning Collaborative, states as laboratories: informing the national public health accreditation dialogue. *J of Public Health Manag Pract.* 2006;12(3): 217-231.

¹² Exploring Accreditation. Final recommendations for a voluntary national accreditation program. Available at: <http://www.exploring accreditation.org>. Accessed April 24, 2008.

¹³ Mays GP. Can accreditation work in public health? Lessons from other service industries. http://www.rwjf.org/files/publications/other/publichealth_Mayssummary.pdf. Robert Wood Johnson Foundation working paper. Published November 30, 2004.

¹⁴ National Association for County and City Health Officials. Rural Health. Available at: <http://www.naccho.org/topics/hpdp/ruralhealth.cfm>. Accessed April 24, 2008.

¹⁵ Quiram, B; Meit, M; Carpende, K; Pennel, C; Castillo, G; & Duchicela, D. 2004. Rural Public Health Infrastructure. *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 3.* The Texas A&M University System Health Science Center: College Station, TX.

¹⁶ Rural Assistance Center. Public Health Frequently Asked Questions. Available at: www.raconline.org/info_guides/public_health/publichealthfaq.php. Accessed April 24, 2008.

rural public health systems, it is important to examine the unique motivations and challenges to accreditation faced by state and local health departments serving rural areas.

I. Motivations

1. Establishing consistent standards: The most obvious reason for seeking accreditation is to establish consistent standards across public health systems.¹⁷ Consistent standards may increase interoperability and service coordination across agencies while increasing one's ability to objectively measure and examine progress. The structure of public health in rural areas is extremely diverse, presenting a simultaneous motivation and challenge related to the establishment of consistent standards.
2. Improving quality: There has been moderate to strong evidence that accreditation programs in the area of health care delivery improve the quality of care provided. Specifically, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accredited hospitals score higher on measures of clinical quality, reduced mortality, and patient satisfaction.¹⁸ Similarly, National Committee for Quality Assurance (NCQA) accredited health plans had significantly higher scores on clinical quality measures than non-accredited counterparts.¹⁹

With regards to public health, the perception that accreditation could lead to quality improvements is a central motivating force. As part of the MLC, for example, Michigan surveyed 200 local and state public health professionals and found that 90% believe accreditation's purpose was quality improvement that would ultimately improve health outcomes.²⁰

3. Increasing accountability: Public health departments are interested in demonstrating their accountability to stakeholders such as insurers, healthcare providers, and community organizations. Additionally, increased accountability to state and local policy makers may, in turn, lead to an increase in funding allocations.²¹ As adequate financing of public health is central to ensuring a strong infrastructure and capacities, increasing accountability through accreditation may be motivating for rural agencies that often have proportionately fewer resources derived from local sources.²² In addition, achieving greater accountability may allow for a more coherent 'public image' that further establishes credibility and legitimacy as an agency.

¹⁷ Russo P. Accreditation of public health agencies: A means, not an end. *J Public Health Manag.* 2007; 13(4):329-331.

¹⁸ Griffith JR, Knutzen SR, Alexander JA. Structural vs. outcome measures in hospitals: a comparison of the Joint Commission and Medicare Outcomes Scores in hospitals. *Quality Management in Health care.* 2002; 10(2): 29-38.

¹⁹ Beaulieu DN, Epstein AM. National Committee on Quality Assurance health-plan accreditation: predictors, correlates of performance, and market impact. *Medical Care.* 2002; 40 (4): 325 – 37.

²⁰ Michigan Local Public Health Accreditation Program. The Accreditation Improvement process. Available at: <http://www.accreditation.localhealth.net/AQIP.htm#SFinal>. Accessed April 28, 2008.

²¹ Congressional Quarterly. Public health: Costs of complacency. Washington, DC. Governing, City and State, 2004. February 24, 2004.

²² Meit M, Ettaro L, Hamlin B, Piya B. Financing rural health activities in prevention and health promotion. Walsh Center for Rural Health Analysis Working Paper. Submitted for client review August 2007.

4. Increasing staff morale: Accreditation may lead to greater collaboration and coordination within agencies that undergo accreditation.²³ In rural areas, where workforce shortages are higher and staff tend to be less likely to have public health training, increasing staff morale may be a subtle yet important motivation for seeking accreditation.
5. Developing Best Practices: Exchanging information and sharing relevant resources, as seen with the MLC states, may serve as a platform for agencies serving rural jurisdictions to implement accreditation programs and enhance the quality of public health services.

II. Challenges

1. Resources: Accreditation often entails substantial costs, including application fees, survey fees, staff training, time, and preparation for site visits.²⁴ As a result, final costs could create an unanticipated financial burden for public health agencies. In one study looking at hospital accreditation, cost was the most important predictor of deterring rural hospitals from seeking JCAHO accreditation.²⁵
2. Lack of Short Term Benefits: The goals of public health agency accreditation are to improve both health department operations and, ultimately, to improve public health outcomes. To date, however, there has been little evidence suggesting a strong and direct relationship between accreditation programs and these public health outcomes.²⁶ As past research has relied heavily on observational designs, the impact of accreditation programs on health outcomes remains highly speculative. In addition, there have been a wide variety of measures and methods used to evaluate the impact of accreditation programs, making results hard to compare.

The potential benefits of voluntary accreditation programs may be even more difficult to assess in rural areas given the wide variance in the rural public health infrastructure. In particular, many have noted that the public health infrastructure in much of rural America is weak, with many rural communities having little access to local governmental public health services and resources.²⁷ In addition, comprehensive cost-benefit analyses are often challenging when LHDs, even within-states, tend to vary significantly in terms of the resources needed for accreditation.²⁸

²³ Russo P. Accreditation of public health agencies: A means, not an end. *J Public Health Manag.* 2007; 13(4):329-331.

²⁴ Mays GP. Can accreditation work in public health? Lessons from other service industries. http://www.rwjf.org/files/publications/other/publichealth_Mayssummary.pdf. Robert Wood Johnson Foundation working paper. Published November 30, 2004.

²⁵ Brasure M, Stensland J, Wellevor A. Quality Oversight: Why are Rural Hospitals Less Likely to be JCAHO Accredited? *The Journal of Rural Health.* 2000; 16 (4): 324-336.

²⁶ Joly B, Polyak, G, Davis MV, et al. Linking accreditation and public health outcomes: a logic model approach. *J Public Health Manag Pract.* 2006; 12(5): 436-445.

²⁷ Meit M, Ettaro L, Hamlin B, Piya B. Financing rural health activities in prevention and health promotion. Walsh Center for Rural Health Analysis Working Paper. Submitted for client review August 2007.

²⁸ Tremain B, Davis M, Joly B, et al. Evaluation as a Critical Factor of Success in Local Public Health Accreditation Programs. *J Public Health Manag Prac,* 2007; 13(4): 404-409.

3. Organizational capacity: Rural health departments tend to be smaller and have fewer resources than their urban counterparts²⁹, which may be an additional barrier to accreditation. In the case of both JCAHO and NCQA accreditation, hospital and HMO size was negatively associated with seeking and receiving accreditation respectively.³⁰

Hospital studies have also found that, in addition to the staffing needs and costs associated with the accreditation process, limited organizational capacity also affects the probability of accreditation approval among rural hospitals. After conducting a survey of 387 small rural hospitals, findings revealed the hospitals had low levels of pharmacist staffing, use of technology, and medication safety practices, all of which were significantly associated with accreditation.³¹

4. Workforce capacity: Public health workforce issues have been a particular challenge to rural areas as a result of location, the lack of advanced education programs, and budget constraints.³² As a result, rural public health personnel tend to possess a more limited range of public health skills in comparison to urban equivalents.³³ While strengthening and credentialing the public health workforce may be an incentive to establishing a national and voluntary accreditation program of LHDs in general, in rural areas this may serve as a disincentive. In some cases, accreditation programs have already begun asking agencies to present evidence of licensure and credentials of their employees,³⁴ which is likely to be a challenge for many rural agencies.
5. Perceived Lack of Applicability to Rural Jurisdictions: A significant barrier to seeking accreditation may be beliefs and perceptions that accreditation standards are not easily applied to rural jurisdictions. Surveys of rural hospitals have found that the second and third most stated reasons for not seeking accreditation are that they believe they “have no need or see no value to JCAHO accreditation;” and that “JCAHO standards are unrealistic for small rural hospitals.”³⁵ In addition, rural HMOs expressed frustration with NCQA accreditation because they believed it to be a “one size fits all” process that overlooks the subtleties and differences in their local health care delivery systems.³⁶

²⁹ Hajat A.; Brown C., Fraser M. Local public health agency infrastructure: A chartbook. National Association of County and City Health Officials (NACCHO) and the Robert Wood Johnson Foundation. Washington, DC: 2001-97.

³⁰ Casey M, Klingner J. HMO serving rural Areas: Experiences with HMO accreditation and HEDIS reporting. *Managed Care Quarterly*. 2000; 8(2): 48-59.

³¹ Casey M, Moscovice I, Davidson G.. Pharmacist staffing, technology use, and implementation of medication safety practices in rural hospitals. *Journal of Rural Health*. 2006; 22(4): 321-330.

³² Meit M, Ettaro L, Hamlin B, Piya B. Financing rural health activities in prevention and health promotion. Walsh Center for Rural Health Analysis Working Paper. Submitted for client review August 2007.

³³ Rosenblatt R, Casey S, Richardson M. Rural-urban difference in the public health workforce: Findings from local health departments in three rural western states. University of Washington: WWAMI Center for Health Workforce Studies, Working Paper. 2001; 61: 1-27.

³⁴ Baker E, Stevens R. Linking agency accreditation to workforce credentialing: A few steps along a difficult path. *J Public Health Manag*. 2007; 13(4): 430-431.

³⁵ Brasure M, Stensland J, Wellevor A. Quality Oversight: Why are Rural Hospitals Less Likely to be JCAHO Accredited? *The Journal of Rural Health*. 2000; 16 (4): 324-336.

³⁶ Casey M, Klingner J. HMO serving rural Areas: Experiences with HMO accreditation and HEDIS reporting. *Managed Care Quarterly*. 2000; 8(2): 48-59.

6. Distributed Authority for Public Health: Finally, it is important to note that many rural areas are not under the jurisdictional authority of a local health department. Depending on the state and jurisdiction, residents often rely on efforts from other rural agencies, including hospitals, health care providers, and community based organizations, as well as state agencies, to deliver public health services.^{37 38} The implications of such structures for both state and local health department accreditation efforts have not yet been determined.

Summary

Health departments responsible for rural jurisdictions face unique challenges in both approaching and achieving accreditation standards. At the same time, rural agencies may also have unique motivations for seeking accreditation that can be enhanced through appropriate efforts to incentivize the process. The most widely adopted voluntary accreditation programs offer strong and visible incentives to organizations in their service industry. The strongest incentives are those that expand business and funding opportunities for the organization through increased access to grants, contracts, and reimbursement preferences.³⁹ In looking at how these types of incentives differ among rural and non-rural health departments, one need only look at the Illinois Project for Local Assessment of Needs (IPLAN) certification process, which included a base grant of \$50,000, as well as eligibility to participate in broader programs for the State Department of Human Services. Interestingly, as Illinois began to replace the IPLAN certification plan with a state-wide voluntary accreditation program, more urban areas of the state urged the consideration the new accreditation process, while more rural parts sought to sustain existing certification practices.⁴⁰

In addition, non-financial incentives can also be considered, including networking and professional development opportunities, professional recognition, validation of the health department's work, and access to performance information databases.⁴¹ The accrediting program can also facilitate the application process by increasing access to resources and services to agencies and providing continuous specialized support.

Finally, we would be remiss if we did not mention regionalization as a potential strategy for creating a "critical mass" of resources necessary to deliver public health services that meet accreditation standards. Regionalization increases the level of technical resources available to public health agencies and facilitates the development of networks and the sharing of resources across counties. In addition to regionalization serving as a strategy to meet standards, efforts to establish consistent

³⁷ University of Pittsburgh Center for Rural Health Practice. *Bridging the Health Divide: The Rural Public Health Research Agenda*. Bradford, PA: University of Pittsburgh at Bradford; 2004.

³⁸ White LA & Silver L. *Rural Public Health Infrastructure: Case Studies to Assess the Impact of Structure on Service Delivery*. Bethesda, MD: Walsh Center for Rural Health Analysis, NORC; 2006.

³⁹ Mays GP. Can accreditation work in public health? Lessons from other service industries. http://www.rwjf.org/files/publications/other/publichealth_Mayssummary.pdf. Robert Wood Johnson Foundation working paper. Published November 30, 2004.

⁴⁰ Landrum L, Bassler E, Polyak G, Edgar M, Giangreco C, Dopkeen J. Local public health certification and accreditation in Illinois: Blending the old and the new. *J Public Health Manag*. 2007; 13(4): 415-421.

⁴¹ Mays GP. Can accreditation work in public health? Lessons from other service industries. http://www.rwjf.org/files/publications/other/publichealth_Mayssummary.pdf. Robert Wood Johnson Foundation working paper. Published November 30, 2004.

standards across agencies can, in turn, help to promote regionalization. In 1993, for example, the American Red Cross's accreditation and re-chartering program led to the successful merging of poorly performing and small local chapters.⁴² Similar outcomes seem feasible among small and rural health departments.

⁴² American Red Cross. Performance driven chapter evaluation system: report and recommendations of the chapter performance standards workgroup. February, 2004.

4. Expert Panel

Introduction

The purpose of the expert panel discussion was to enhance understanding of how public health infrastructure may dictate rural public health departments' approaches to seeking accreditation. Through the panel, NORC sought input from eleven representatives of local health departments (LHDs) located in rural areas. This section describes findings from this first phase of the research study. Through the panel discussion, NORC sought to gain insights into *why* local health departments serving rural areas have sought or will seek accreditation; *how* those agencies are likely to approach accreditation (e.g., through regional collaboration, consolidation, etc.); what *barriers* to accreditation they may face; and what *strategies for accreditation* these communities, and communities not served by LHDs, are likely to use.

Methodology

Study Design

The expert panel approach to qualitative data collection is predicated on bringing together individuals who share some common characteristics and experiences. These commonalities help to foster open, interactive, and informative discussions. Because NORC recognizes the importance of representing individuals with a mix of knowledge and attitudes toward LHD accreditation, we used a pre-panel questionnaire (see Appendix 1) to identify participants with diverse backgrounds in terms of their familiarity and direct experience with accreditation.

NORC worked closely with CDC and NNPHI to develop structured protocols for the expert panel discussion in order to highlight salient points related to rural agency accreditation. Specific areas of focus included benefits of and barriers to rural health department accreditation, as well as strategies for supporting rural LHDs to become accredited. Protocols were approved by NORC's institutional review board.

Recruitment and Selection of Panelists

The Walsh Center distributed a call for panelists through its extensive rural stakeholder listserv, and, in partnership with NACCHO, to rural health departments throughout the nation. All potential panelists were sent a brief, pre-panel questionnaire. Responses were used to select a broad cross-section of panelists, serving varying population sizes and compositions, with varying LHD capacities, varying levels of experience with accreditation, and varying opinions, both positive and negative, regarding accreditation of rural LHDs. Topics covered in the pre-panel questionnaire included:

- Size of population served by the health department;
- Makeup of the population served;
- Total number of staff employed by the health department;
- Characterization of the health department as urban, suburban, or rural;

- Level of familiarity with accreditation of health departments;
- Reasons for interest in accreditation;
- Presence of an LHD accreditation initiative in the state;
- Current LHD accreditation status; and
- Experience with/opinions of accreditation.

In addition to the pre-panel questionnaire, potential panelists were classified by degree of rurality using Rural Urban Commuting Area (RUCA) codes, as assigned by NACCHO as part of its *2005 National Profile of Local Health Departments*.⁴³ The RUCA system is one of several ways to classify rural areas. Using the U.S. Census Bureau's definitions of Urbanized Areas and Urban Clusters, it is based on the size and population density of cities and towns, and their functional relationships as measured by workforce commuting flows. RUCA codes are defined on a scale from 1 to 10 and higher, with 1 being an "Urban Core" Census tract, and 10 and higher being "Isolated Rural" tracts. The Federal Office of Rural Health Policy (ORHP) uses the convention that all counties with a RUCA designation of 4 (defined as "Micropolitan" in the 2000 Census) and higher are classified as "rural."

For the *2005 Profile*, NACCHO used zip code information from its membership database to classify all LHDs by RUCA codes. Inasmuch as the LHD's physical address is an imperfect measure of rurality, there are inherent flaws in this methodology. For example, as the LHD is likely to be headquartered in a jurisdiction's population center. Given that LHDs are likely to be *more* rural than indicated in our selection criteria, we felt this was not a major concern. (See Appendix 2 for additional detail on the NACCHO study's use of RUCA codes.)

In selecting LHDs, it was also important to recognize that they serve several different types of jurisdictions (counties, cities, city-county, townships or towns, and larger regions) with a wide range of population sizes. Therefore, an LHD classified as "rural" in one area may serve a population that is the same size, or an even larger, than an LHD classified as "micropolitan" or "urban" in another region. Given the likelihood of such variance, we also used geographic region as a selection criterion. By using both geographic region and RUCA classifications, we believe that we were able to select a wide range of LHDs in terms of degrees of rurality, health department capacities, and populations served.

Study Participants

Characteristics of participants and LHDs are shown in Exhibit 1, below. The level of rurality of these health departments (as indicated by the RUCA codes) ranged from "Isolated Rural" (10.5) to "Weakly Tied to an Urban Core" (3). The mean of RUCA codes for all LHDs represented in the panel was 5.8.

⁴³ This study was the fourth such National Profile of Local Health Departments conducted by NACCHO. A detailed description of the National Profile Study can be found at: <http://www.naccho.org/topics/infrastructure/2005Profile.cfm>.

Participants' answers to the pre-assessment questionnaire indicated that all who responded had some level of familiarity with the concept of voluntary accreditation. There was an even split in responses among those who considered themselves to be "very familiar" with accreditation (three responses), "familiar" with accreditation (three responses) and "somewhat familiar" with accreditation (three responses). One panelist did not respond to this question; another was a second representative from an LHD in the state of Maryland who did not fill out the questionnaire. Most panelists (six) said the LHDs they represented were not accredited; two were from accredited health departments.

Exhibit 1: Characteristics of Participants in Expert Panel Discussion Group

State where LHD is Located	RUCA Code	Level of Familiarity with Voluntary Accreditation	Currently Accredited Health Department?
Arizona	7.0	Somewhat familiar (SF)	No
Colorado	7.0	Somewhat familiar (SF)	No
Kansas	3.0	Familiar (F)	No
Maryland*	10.5	Familiar (F)	Yes
Michigan	4.0	Very Familiar (VF)	Yes
Nebraska	4.0	Somewhat Familiar (SF)	No
New York	4.2	Missing	Missing
North Carolina	7.0	Very Familiar (VF)	No
Oklahoma	7.3	Familiar (F)	No
Washington	4.0	Very Familiar (VF)	N/A
Summary Statistics	5.8 (Mean)	VF (3); F (3); SF (3)	Yes (2); No (6); Missing/ NA (2)

*The Panel included two representatives from the same LHD in the state of Maryland (a total of 11 panelists).

Methods of Qualitative Data Analysis

The expert panel was facilitated by a NORC researcher who has successfully moderated numerous panel meetings. The researcher followed a structured discussion guide and provided probe questions to explore certain aspects of the discussion in greater detail. To ensure accurate data collection, NORC researchers audio taped the panel discussion, took extensive notes during the discussion, and analyzed and coded the notes for central concepts and themes. Concepts that emerged during the discussion followed categories germane to the primary questions in the expert panel protocol, as well as additional topics of interest. To offset the potential for subjectivity in the analysis process, multiple NORC researchers collaborated on reporting and interpreting findings.

Study Limitations

Participants in this panel discussion were individuals who took the initiative to respond to a call for panelists, distributed through the Walsh Center and NACCHO rural listservs. Moreover, they were willing to travel to the Washington, D.C. area from locations as far away as Washington state and Arizona. This high degree of motivation demonstrated strong feelings about accreditation that may not be typical of the general population of rural public health professionals.

In social science research, the discussion group approach is intended to offer insight and guidance, rather than quantitatively precise or absolute measures. Due to the limited number of individuals taking part in the expert panel, the findings of this research should be considered in a qualitative frame of reference. As with all convenience sample research, the results can be considered valid in representing the participants' perspectives, but cannot be generalized to a given population.

Findings

In this section, we present findings from the expert panel discussion on LHD accreditation in rural areas. The summary highlights general themes from the written moderator's guide that was used to lead the day's discussion, but topics have been rearranged and condensed to avoid repetition and enhance readability.

Effects of Rurality on LHD Readiness for Accreditation

Do efforts toward consistent standards/services create unique challenges for rural LHDs?

Most panelists agreed that efforts towards creating consistent standards do in fact create unique challenges for rural LHDs, as compared with more urban ones. Variance in the quality and nature of services delivered among rural LHDs and across states was noted as one factor that inhibits progress towards accreditation. One panelist reported that in her state, "there is a broad spectrum of services that are provided." However, another participant felt that the challenge is related more to the fact that different entities deliver services in different states—not simply that different services are delivered. He said, "It is not variance per se (that impedes accreditation). We need to look at who delivers the various services. This is vastly different by state and LHD."

Is accreditation a priority among rural LHDs?

Most panelists believed accreditation is not viewed as a priority by rural LHDs. A panelist commented, "Accreditation is not a priority, and neither is quality improvement." She said that

many LHDs are focused on capacity and resource issues rather than accreditation. “Until they have the capacity, they feel that they can’t address this issue.” Two panelists said that the lack of an adequately trained workforce that can see the relevance of accreditation is also problematic. Another person pointed out the rural LHDs are struggling to do the day-to-day business of supporting public health, which leaves little time to consider issues such as accreditation.

Several participants noted that policy-makers such as county commissioners and governors do not currently see the value of accreditation. They viewed this as a particular hindrance for small rural health departments that may not get the “seal of approval” to pursue accreditation efforts from their local decision makers. Rather, they noted that county commissioners, in particular, may be wary of accreditation as they feel that “they will be forced to pay money for it.”

Do you feel that meeting LHD accreditation standards will be more challenging based on specific LHD features?

Panel participants had differing views of the role that specific LHD characteristics (such as size, jurisdiction type, or population served) play in shaping whether or not an LHD meets accreditation standards. One individual said that all of these factors are relevant. Another argued that variation in the scope of public health services offered by different jurisdictions was a more significant issue. He asked, “How do you apply some sort of standard template across different health departments?”

Are there differences in the incentives and motivations for larger and more urban departments, as compared to smaller, more rural health departments?

When asked whether the motivations for small, rural health departments to take part in accreditation differ from those of larger, urban health departments, the panelists all verified that such differences do exist. However, rather than contrasting these motivations, the panelists focused on differences in capacities that may influence the accreditation process. Themes addressed in this discussion included variation in access to funding and resources, as well as staff training and coverage.

One person said, “Most health departments that have more than \$7 million (in funding) perform exceptionally well. Having enough population and monetary support makes a significant difference in performance of standards.” Another resource mentioned was access to academic institutions. It was noted that LHDs that are located in university towns have an advantage in that they are able to tap the expertise of academic departments. One person pointed out that for these LHDs, “access to resources through academia will assist them in accreditation.” Agreeing, another person added that urban departments have better access to universities, while “smaller, rural counties are left out.”

Having an available academic partner also influences access to well trained staff, and ongoing staff training. In one situation, the presence of a school of public health in the community made it “easier to recruit and educate staff and obtain funding in partnership with the university.” When staff members have public health training, there is not only a stronger capacity to do the work for accreditation, but also they are more likely to understand the value of this process. One panelist stated that “staff in urban health departments easily understand the benefits (of accreditation).” Another commented that rural LHDs are typically staffed by people from the community; they learn on the job, and are not formally trained in public health.

In addition to staff training opportunities, panelists also noted that there are often basic differences in staffing numbers in urban versus rural LHDs. One panelist observed that “when an RFP comes out, the larger departments have staff members who have the time and skills to write grants.” She explained that in small, rural LHDs, such tasks are sometimes performed by one person. If these

LHDs undergo accreditation, the responsibility for doing the work falls on that individual, while bigger health departments have more resources. “It is not a fair system,” she added.

Is there buy-in among rural LHDs for accreditation efforts?

None of the panelists felt that staff members in their LHDs were completely on board with the idea of accreditation. One person said that the staff members are interested, but the buy-in is “not that great.” She said that before they support it, staff members want to know “if it is going to change what they do, and whether that would improve things.” Another person suggested that if accreditation were linked to activities that LHDs are already engaged in, it could be seen as a way to improve performance and it would be “much easier to sell.”

Mentioning that emergency preparedness funding had “re-routed” LHD activities, a panelist said, “Staff recognize that they are not spending as much time in the field because of (preparedness) activities.” He added that accreditation efforts would require redirecting funds from services to assessments. As a result, another person argued, “Smaller health departments may need (relatively) more funding than the big departments,” because LHDs with fewer staff may feel more pressure to avoid spending limited resources on assessments/evaluation as opposed to delivering services.

Are local partnerships with community organizations impacted by accreditation efforts?

Several panelists expressed the view that accreditation has a beneficial impact on local partnerships with community organizations. One said, “In some instances, it will give you better standing. Local hospitals know what accreditation means, so it would give you better standing with them.” Another person remarked that the fact that their LHD got JCAHO accreditation did open lines of communication with a hospital. A third panelist verified that accreditation had brought more recognition to the LHD, as demonstrated by an increase in the referrals it received for in-home care after accreditation. Another person reported that her county didn’t experience such direct results from accreditation, but it was a factor in contributing to quality improvement at the LHD.

Other panelists were more measured in their views of whether accreditation fosters partnerships. One said that accreditation is a “budget drain.” Another remarked, “On a rural level, (credibility) is all about personal relationships; accreditation may not matter as much.” Additional downsides that were discussed included the fact that pursuing accreditation takes time away from engaging with communities, thereby hampering the development of key relationships. It was also noted that in areas where educational levels are low, the “seal of approval” represented by accreditation does not have much value. She said, “Our public health agency is well respected because of the work we do. The community sees us as the most honest, reliable agency in the county.”

What are the competing priorities in your communities that may influence decisions to move forward with accreditation?

Panelists were fairly consistent in their statements that LHD priorities are often driven by funding and resource issues (including staffing). One person remarked that at his LHD, “Staff do preparedness because they are told they have to. Their direction is driven by the state and siloed funding, not by what is going on in the local level.” Another person said that in his county, preparedness is also a priority because if something goes wrong, “we will be held accountable.” The issue of difficulty in communicating with county commissioners resurfaced, with one person commenting, “It is problematic because priorities are determined by the Commissioners, and therefore change every few years.”

Two panelists discussed the importance of staffing and public health infrastructure. “There is an aging public health nursing population,” one said. She thought that being able to do assessment planning and hire staff with some public health experience were also priority issues. Another person said that within his LHD, securing more money for programs and infrastructure is the focus. He remarked, “Morale for the (staff) is just terrible because of poor working conditions.”

Motivating Factors

What are the primary benefits for individual LHDs to seek accreditation?

Enhanced Capacity and Quality

As they discussed the benefits of accreditation, Panel members returned repeatedly to the themes of enhanced capacity and improved quality of services. Several participants saw these as being linked. “Accreditation and capacity and quality go hand in hand,” one remarked. A panelist from an accredited LHD (mandated by the state) reported that accreditation had led to significant quality improvements for her agency. In particular, she said it had improved operational consistency among all branch offices of their LHD (e.g., their computer and filing systems now use the same format).

Some participants believed a key benefit of accreditation would be to promote uniformity in the quality of services delivered *across* health departments. For example, one said, “There is a disparity in the level of public health available in each county. Accreditation would create a system (to ensure) the same quality of public health services across counties within one state.” Another panelist warned that unless LHD accreditation becomes mandatory, only LHDs with more resources would “sign on.” Those with fewer resources would not. (This person believed, however, that accreditation could initially be voluntary).

A third person noted that going through the accreditation process could help “raise the bar” for small health departments, helping them to identify and fill current gaps in their capacity by tapping resources at the state level. This person said that “If an LHD doesn’t have any staff with epidemiology expertise, for example, accreditation could allow them to identify these gaps and assess available state resources...to improve on those weaknesses.”

One panelist noted that the benefits of accreditation to the public health community as a whole outweigh those to individual LHDs, because the quality of public health services delivered across health departments varies dramatically. His view of the value of accreditation is that it would provide, “the ability to look at services across the range of counties.”

Improved Credibility and Recognition of the Role of Public Health

A number of panelists felt that accreditation would bolster esteem for the role of public health—both in the community and among LHD staff. One panelist noted, “It is hard to define for the community what (the LHD does), and what public health is about.” She expressed her hope that, “The accreditation process will provide a foundation to explain what we do in terms of services.” Another participant believed that accreditation would build morale among staff, encouraging them “to work together as a team once they understand what they are trying to achieve.” This person also felt that accreditation would help LHDs to recruit staff. In a similar vein, a panelist said that accreditation would “validate the health department,” and provide credibility.

This desire for external recognition was echoed by other members of the panel. One reported that their LHD has paid for JCAHO accreditation twice—first in the 1990s, and then again last year. The LHD’s original rationale for accrediting their healthcare delivery services was that they thought they would receive better insurance reimbursement. However, they found that they gained another benefit—“a sense of worth and pride that spread across the whole department.” Financial constraints have been an issue when deciding to allocate funds for this, but the LHD still feels “it is worth keeping.”

Advantages Related to Funding

When asked whether accreditation helps rural LHDs to leverage funding, one panelist reported that her department has not been able to obtain additional funding as a result of becoming accredited. Nonetheless, she felt it has protected them from funding cuts, and said an accredited health department in a nearby city had received significant funding. In her view, accreditation would help states to ensure that all LHDs receiving funding are meeting certain standards, and are measured at the same level. This would create a healthy level of competition among LHDs.

Other panelists seemed uncertain of the impact accreditation would have on their ability to leverage funding. One remarked, “Until you see outcomes, it will be hard to secure funding.” She noted that some JCAHO-accredited hospitals are “in poor shape.”

One panelist from a county where the LHD provides primary care services said that LHDs should “get reimbursed like hospitals” once they are accredited. Another mentioned that accreditation standards could facilitate performance evaluation for non-governmental agencies involved in administering Medicaid and Medicare (the specific example mentioned involved Medicaid administration in New York State).

Enhanced Collaboration

Responding to a question about whether accreditation fosters community buy-in and support, a participant explained, “Many folks are still not knowledgeable about accreditation, even though we have put the word out.” She emphasized that it is important to show that LHDs are interested in building collaborative relationships, and in communicating with partners. Another panelist noted that there are many different groups involved in public health. Accreditation could foster interaction among these stakeholders, encouraging collaboration to meet high standards. Collaborations could help to avoid duplication of efforts within communities, and to stretch scarce resources. It is important for staff to realize that community members are potential partners for their agencies.

What could be motivations and incentives for LHD to seek accreditation?

Designated Funding for Accreditation

The panelists suggested that designated funding for accreditation would be critically important, both for motivating LHDs to pursue it, and for paying for the resources LHDs would need to invest to become accredited. One participant reported that her state “starts to put money into the (local) health departments the year that they are seeking accreditation.” Another panelist said that in a voluntary accreditation system, federal money could eventually be linked to accreditation to motivate LHDs to undergo the process. A funding stream would be especially important because, although county commissioners sometimes comprise the boards of health, they may not be well informed

about public health. A panelist said that in her county this would present an obstacle because, “County commissioners couldn’t care less about the accreditation initiative. They will say this is an unfunded mandate.” It was also suggested that funding should ultimately be tied to accreditation.

Enhanced Capacity and Performance

Two panelists indicated that going through the accreditation process would help them to better understanding their performance gaps, allowing them to then build/expand capacities in those areas. This was seen as a strong motivating factor. Because her LHD is located in a rural, sparsely populated county, one said her LHD would be motivated to seek accreditation by the opportunity to take part in a regional effort because “otherwise we don’t have the ability or workforce to build that capacity.” She said accreditation would help to address workforce issues by building collaboration between regions to “meet the mark, and deliver what people need.” The prospect of receiving “training tied to accreditation standards is a motivator,” a second panelist said. Another suggested that the accreditation process would motivate LHDs “to make sure they do what they should be doing.”

With a longer-term view towards enhancing the capacity of LHDs, a panelist suggested that tying training to accreditation may encourage more schools to offer undergraduate-level public health courses and programs. This would be particularly important for rural LHDs, which tend to hire from the surrounding community, and may not have access to a recruitment pool of workers with graduate-level training.

Communicating about the Role of Public Health

Again, the opportunity to clarify the role and function of public health to the community, staff, and other stakeholders was mentioned as an incentive for LHDs to become accredited. One person remarked that accreditation “gives the department more of sense what they are doing, and helps to communicate with the public about what they are doing.” He remarked that the purview and responsibilities of LHDs have been expanding: “Every week something new comes up. Things such as gun safety, meth labs, and suicide are dumped onto public health.” Using accreditation as a tool to communicate the role and functions of public health may help to maintain focus as responsibilities continue to expand. Another person suggested that accreditation offers a chance to ask what the field of public health needs to do to “market” itself better.

Standards for Evaluating Performance

Panelists noted that accreditation would provide standards that would help LHDs to assess their work and identify areas for improvement. Yet this benefit could be a double-edged sword. One panelist reported that during a recent LHD meeting about accreditation, the nursing director said, “The good news is we have a chart audit policy; the bad news is if we use it to take measures, we may not meet the standard.” Thus, going through accreditation would require LHDs to “look in the closet to find the skeletons.”

Barriers Rural LHDs Face in Seeking Accreditation

Lack of Understanding among Staff Members and Lack of Time to Commit to Accreditation

A panelist emphasized that inadequate staff training about accreditation is a significant barrier. He commented, “These are highly trained professionals who know how to deliver (public health services), but they’re not familiar with quality improvement concepts, or tools used to do this.” Offering another perspective on how staff members may perceive accreditation, another person said, “When you first start this process, staff members fear they are being evaluated, rather than focusing on the process (of accreditation).” This anxiety is “a big barrier,” she explained. “It is hard for them to get over.”

One person suggested that staff members may not necessarily be receptive to receiving additional training. She said, “Even when you offer it to them to get training, most do not want to do it.” Another explained that very few staff members have an MPH degree. She said, “It is not that people don’t care, but they don’t understand the true mission of public health.” However, another panelist seemed hopeful that LHD staff could be convinced of the importance of accreditation. “It takes a lot of work, but they eventually get there, especially when they are convinced that it is not a punitive process.” He added that when his LHD pursued JCAHO accreditation, “everyone ran and hid at first.” However, the culture eventually changed, and “staff now sees the value.”

Panelists mentioned that LHD staff members simply don’t have the time to pursue accreditation, especially since inadequate staff coverage is often an issue. Therefore, staff members may need to be convinced that, “this isn’t going to be an additional burden to them, and instead may be of some relief. They need to understand this will make their life better.” One person emphasized that the participants in the panel are not necessarily representative of the general population of LHDs in their enthusiasm for LHD accreditation. He said, “Everyone (in this group) is passionate about public health, but sometimes colleagues in the field are too busy doing their job to get caught up in this issue. Few small rural health departments see the benefit.”

Lack of Funding and “Siloed” Funding Streams⁴⁴

Panelists expressed frustration at the paucity of grants designed for small agencies. One explained that funders often fail to understand the costs faced by these LHDs. Several panelists discussed the difficulties that LHDs face in administering small grants. Explaining that staff burnout is the result when grants do not cover all costs, one person said, “You add more things for them to do, and they don’t feel like they are compensated.”

Another panelist reported that his LHD had performed a cost analysis on some small grants in the amount of \$25,000. Their results indicated that it would take \$50,000 to administer the programs. He said, “If the grant is not over \$25K, it is not going to be beneficial, and will result in more work than the grant can cover.” “Part of the problem is that we chase every dollar,” another panelist stated. “This may be one more thing we don’t have the money to do, but in the end it may help us

⁴⁴ More information on the topic of rural public health financing can be found in the Walsh Center’s 2008 report entitled “Financing Rural Public Health Activities in Prevention and Health Promotion,” available at <http://walshcenter.norc.org>.

get more money.” On a related point, a panelist noted that funders’ expectations for what can be accomplished with grant funding are “huge.”

Panelists also talked about the problem of “siloed funding” (i.e., funding streams that are directed to specific diseases and conditions). Explaining why this would present challenges in preparing for accreditation, one person said, “It’s hard to fit (the accreditation) process with the current funding, because it doesn’t allow for flexibility beyond three percent for indirect costs.” Another panelist remarked that specific diseases do not exist in a silo. He offered diabetes as an example. “One of the criteria for the diabetes grant is that (the program must) get twenty folks who are pre-diabetic, and implement primary prevention for them.” Yet he said that the program cannot address these preventive issues due to funding constraints.

Lack of Consistency among Public Health Systems

Several panelists mentioned the “fragmentation of the (public health) system” as a major barrier to accreditation. “Public health in LHDs is different everywhere,” one panelist said. “If standards don’t acknowledge that everyone is starting at a different place, then that is the biggest barrier.” Another panelist indicated that the accreditation system should be “set up to acknowledge where (LHDs) are (in their level of functioning), and to encourage them to move to the next level.”

A lack of consistency across public health systems limits accountability for outcomes, according to the group. Accreditation should ensure accountability, but panelists said that in fact this end is simply “not possible with the current fragmented system.” Further, given the fragile nature of the public health system, a panelist felt that “accreditation...might be a barrier in the first year or two (of implementation) if it happens during a crisis.” It was emphasized that flexibility will be critical to ensure that “people who just entered the journey (of becoming accredited)” are not alienated from the process.

Problems in Collecting Consistent, Accurate Data

The group also discussed problems relating to how data are collected across counties. One asked the question, “How can LHDs make sure that they are using valid data, especially when they are not all collected the same way?” Another commented that when her LHD was found to be “at the bottom regarding immunizations,” questions arose about whether everyone who was reporting data was measuring or collecting it in the same way. Another panelist said, “It doesn’t matter what you measure, as long as you start measuring something. You have to start somewhere. Then you will know what (interventions) really make a difference.” He said that the key is to find indicators that will serve the function of, “These ten things can answer the question, ‘am I doing my job?’”

Lack of Short-Term Benefit

One of the panelists said there is simply no way to know whether or not accreditation will lead to improved outcome measures in the long term, and there is little likelihood of demonstrating short-term benefits. Illustrating this point, he commented that “the Air Force did continuous quality improvement in 1970’s, and there were no real outcomes until 1990.” Another panelist expressed uncertainty that an initial, voluntary accreditation system should strive to push toward improved outcomes. She said, “They first have to get folks excited and not scared to jump in. But improved outcomes are certainly the long term goal.”

Lack of Awareness of Accreditation among Decision-Makers

Several people mentioned that, although policy-makers such as county commissioners and governors “need to see the value” of accreditation, “right now they don’t.” They viewed this as a hindrance to small rural health departments becoming accredited. One panelist brought up the fact that in small counties, county commissioners often do not understand public health, and are particularly wary of unfunded mandates. Another explained that county commissioners may view accreditation as a threat because, “commissions feel like they will be forced to pay money for it.” In thinking about a solution to this problem, one person emphasized that the relationship between local officials and the board of health is important to consider. “How can you sell accreditation so that people think it will make a big difference?”

Strategies for Rural LHD Accreditation

Conduct Education and Training of Staff

To motivate staff members, one panelist said, it will be necessary to “let staff know that there is a problem, and that it is real.” Several panelists talked about educational opportunities such as workshops and conferences as a way to help rural health departments build towards accreditation. Bringing rural public health professionals to events in urban areas would be an option. One person also suggested, “You have to come out to rural areas. There should be more of these sessions (like the NNPHI accreditation panel). And tap into agencies other than public health, as well.” Other suggestions included mentoring volunteers and providing public health core competency training.

One panelist expressed the view that if accreditation led to practice standards, there would be support for pursuing it. Another commented, “If we had a measurement stick that we could put up to show the great job that we are doing, it would be good.” A panelist reported that her state offers certification programs for nurses so that they can adhere to protocols for conducting routine exams and referring patients, and feel good about it. If something like this were to come out of accreditation, it would be useful. Taking these ideas further, another person remarked, “There has to be a demonstration of the value (of accreditation) to what they do – ‘what is in it for me?’”

A panelist said that a CDC staff member had come to his LHD to present on national standards and “this got everyone excited.” He asked whether there might be a way to create a forum for discussing rural public health issues for accreditation at a national level. “What about a version of the NACCHO conference for rural health departments,” he asked. He felt this would be important because “there isn’t a home for rural health departments.” Participants also discussed effective ways to deliver accreditation training, such as using training videos (North Carolina developed one to “give counties perspective on what it is all about,” and to educate boards of health).

Panelists said that LHD’s “should be given tools” to conduct this preparation, rather than being asked to develop their own. As a component of such training, there should be “success stories or good examples,” including benefits that will be easy for LHDs to attain, so that staff can see immediate rewards for accreditation efforts. One of the panelists stated that technical assistance and peer support would be helpful in the process, along with funding “to get it off the ground.” Another noted that a learning module for public health accreditation can be accessed at the website: www.accreditation.localhealth.net.

Having an operational definition of accreditation offered “a great starting point,” one panelist said. In particular, it helped to make accreditation seem less threatening to LHD staff. “They are looking at where their strengths and weaknesses are, and moving forward from there.” She explained that her LHD went from using an APEX assessment to using the National Public Health Performance Standards assessment tool.

Demonstrate the Value of Accreditation to Local Decision-Makers

The questions of political leadership and the need to educate policy-makers about public health were seen as being critical. “It’s all about leadership,” one panelist said. “...No matter what the form of governance, there are very few public health experts (among these decision-makers). We need to create leaders who are interested in this.” Panelists agreed that it’s important to demonstrate the value of accreditation to decision-makers. One said, “You need a real story to back the effort. If we can get the local policy makers engaged, that is key.”

Some panelists were confident that they would be able to convince leaders of the importance of accreditation under the right circumstances. For example, one believed that if she told her commissioners accreditation is an important goal to pursue, they would agree to do it because they trust her. She emphasized that in rural areas, the ability to persuade and educate leaders is often based on relationships. “If you’re an outsider, they are not going to listen to you. You have to be careful about who speaks to each town.”

Another panelist emphasized that accreditation efforts must be backed by funding if they are to succeed among rural LHDs. He argued that this would make a big difference in gaining the backing of county commissioners and boards of health. “If you are presenting a program (to decision-makers) and say, ‘it is not going to cost you anything,’ or, ‘it is going to make you money,’ they will say ‘go for it.’ If you say the county will have to kick in this money, it might not work. You have to give them something that they feel is worth investing in.”

Generate Concrete Outcomes: Action, Improvements

Several panelists cautioned that if accreditation is to enhance the performance of LHDs, it must lead to concrete outcomes and actions. One emphasized, “Just looking at policies is not tangible, it is not going to do anything meaningful.” A panelist said it would be easier to “sell” the idea of accreditation if they could show that it would put the LHD on a clear trajectory toward improved health outcomes, instead of just processes. This person added that it would be nice if LHDs could choose which areas to focus on in making improvements; others agreed that flexibility is needed.

Use Innovative Funding Strategies to Support Accreditation Efforts

Panelists were emphatic that LHD accreditation should not be rolled out as an unfunded mandate, both because county commissioners and governors would be less likely to support it, and because staff do not have the capacity to do additional work without compensation. One person suggested that “money shouldn’t be sent through the states, because they keep it and LHDs don’t get anything.” Another panelist remarked that “there is a model out there already” for channeling funds directly to LHDs. Specifically, she said that Emergency Preparedness Coordinators are being hired through the use of federal pass-through funds to local departments.

Panelists also suggested using accreditation as an opportunity to educate funders about the need for increased flexibility in grant requirements. For example, panelists said that LHDs could conduct more effective primary prevention if they were able to combine funding across programs. Funders

should be made aware that “their category of money for highway safety may also work for bicycle safety and other safety issues in the community.”

Use Tiered or Phased Approaches to Accreditation

The idea of a “tiered” accreditation process was raised repeatedly throughout the panel discussion. Describing how this might work, one panelist said that LHDs “should be allowed to build capacity slowly over time, so that they have time to get into the different stages of accreditation.” She suggested a starring system (i.e., one star, two stars, three stars, etc.) so that LHDs know when they have advanced a level and are making progress. There was also discussion of applying different tiers to different LHDs based on the specific services they provide, as opposed to requiring an LHD to meet all standards to achieve accreditation. Thus, a “full service” LHD might be accredited at the highest tier, while a limited service rural LHD might still be eligible for a lower tier of accreditation.

Agreeing with this notion, another panelist said that LHDs should receive guidance on what standards they should be meeting, based on different variables. Another person said, “You have to crawl before you can walk, and walk before you run. My health department is not even crawling yet, and we are not ready (for accreditation).” It was felt that tiered accreditation “should ensure the same standard for different services.” Nonetheless, a panelist wondered aloud about how a core set of standards would be selected and applied “across the board.”

Form Partnerships with Academic Institutions

Four of the panelists reported that their LHDs are located near universities; of these, two have public health programs that are currently being launched. One LHD representative reported that their staff members were trained by faculty members from a nearby school of public health. Panelists emphasized that university partnerships can be very helpful, but they can be costly. On-line trainings, in particular, were cited as being expensive.

Some panelists felt it may be beneficial to seek out universities to provide technical assistance. Others argued that universities do not see providing technical assistance as part of their job; rather, they are interested in research. One panelist said, “They are not focused on solving the problem, because they are paid to deal with research.” He added that if LHDs want to have a specific course developed, universities would do a good job, but “as far as technical assistance goes, you would get an academic response to a local problem. They would be good if you are collecting data.” Despite these concerns, however, panelists generally agreed that academic partners may help to extend the limited public health workforce when addressing issues such as accreditation.

Engaging National, State and Regional Partners

Do you feel that rural interests are represented in national accreditation efforts?

The panelists did not seem to believe that rural health departments were being adequately represented in national accreditation efforts. One panelist reported that she is taking part in the standards workgroup, so her involvement comprises at least partial representation. Overall, panelists felt that the engagement of rural health officials should be actively sought for national accreditation. Participants felt that for a national roll-out, the rural LHD buy-in “should be valid, and people should be involved.”

Do you feel that rural LHDs have been “at the table” in your state in the development of standards and processes for accreditation?

A panelist reported that Washington State revised its standards and consensus efforts to include input from stakeholders at all levels, including the state, as well as urban and rural LHDs. He said, “Everyone can participate to come up with proposed standards,” and noted that this model worked well. The accreditation process in North Carolina was also described as seeking broad stakeholder input. The panelist from North Carolina reported that her state selected two small, two medium and two large health departments to develop standards. She felt this had been a good way to approach the process, since different sized departments have different levels of capacity.

Describing a dramatically different experience, a panelist from another state said that staff members at the state level in her region have “no idea what it is like to be out in the counties.” While the state itself is looking into accreditation, she was not sure whether local perspectives would be included in that process. This experience was consistent with that of a panelist who said that in her state, “a couple (of LHDs) have been involved in some work, but not enough, and not everyone.”

How should state health departments be involved in accreditation efforts? Can they help facilitate accreditation efforts in the local health departments?

Participants asked whether accreditation of LHDs would imply that states should also be accredited. If so, would the same accreditation process and content be involved? Participants believed that the process and content would probably differ, but should be similar to the LHD standards. One person said, “The questions are different, but if there is a measure for the local health department, there should be a (corresponding) measure for the state. Going back the Medicare/Medicaid programs, there are national standards the States are supposed to abide by. I don’t think it is a leap to tell state public health departments that they should be held accountable.” Participants suggested that states could champion certain accreditation standards to ensure that they are met throughout the state. When state and local agencies are working together to accomplish specific standards, it was felt that legislators, in turn, will support this effort. One panelist commented that, if the state health department was supportive and helped LHDs with financial or other backing, “that would help locals feel like they could accomplish this.”

Regionalization as an Approach to Pursuing Accreditation

Regionalization was mentioned by many panelists as a potential strategy for pursuing accreditation. In the discussions, regionalization was conceptualized in two different ways: (1) as the establishment of a regionalized public health agency across multiple jurisdictions; and (2) as a formalized collaboration between multiple, independent public health agencies. While both types of regionalization were discussed, more focus was placed on the latter strategy.

Regional collaborations are often used to implement public health activities that cannot be achieved by small rural health departments on their own. Participants discussed how accreditation efforts could account for these collaborations, and whether the accreditation process itself could be carried out regionally in some instances. There was some discussion of the fact that regional collaborations and partnerships are attractive to funders and yet, if funding is distributed to coalitions instead of health departments, accountability is sometimes weakened.

One participant said that her state had formed an alliance, and had “actually received some funding after that.” One panelist mentioned two “success stories” of regionalization—in Western New

York and North Carolina. Elaborating on the New York model, he explained that the Western New York Public Health Alliance is a non-profit organization that works across health departments. Each LHD contributes to the alliance based on its population, and each has equal access to its resources. He noted that “Regionalization allows for the same protocols to be followed. Consolidation cuts overhead costs, (and those funds) could theoretically be redirected to accreditation.”

Despite the potential benefits of regionalization, panelists noted that there can be obstacles in using this approach—including variation in the priorities of commissioners from different counties. While the counties have some agreements to work together, there is a lack of universal buy-in from all commissioners when it comes to the issue of accreditation. She said, “Regionalization has to be embraced (in our state) because of limited resources and the large land mass served by only few agencies. However, an issue that may be important to one county may not be important to another.” Creating a formalized, regional governmental unit might be one option, and another would be for counties to maintain autonomy. This panelist said that in her state, “A more formal structure would be received negatively, because a lot of governmental entities would feel threatened.”

Panelists offered some ideas for fostering effective regional collaborations in order to become accredited. One said it would be important to “create legislation stating that the alliance is the body that facilitates accreditation, but the accreditation process is implemented in local health departments.” Another offered the example of his area’s regionalized approach to emergency preparedness planning. They have a regional coordinator for emergency preparedness, but the preparedness plan is developed at the local level. He remarked that if there are independent county health departments taking part in a regional collaboration, accreditation “will still need to happen at local level. The alliance can promote accreditation, and help directors to implement the program by providing assistance, support and encouragement.”

Accountability and Other Factors Driving Accreditation

Who should be responsible for measuring whether or not LHDs meet the standards?

A panelist remarked, “Whoever is responsible for measuring LHDs’ compliance with accreditation standards, they must have more credibility than a peer review system.” Her state mandates that LHDs are accredited, and it uses peer reviews. This approach “doesn’t have the same stature as JCAHO accreditation.” To be meaningful, she felt accreditation would need to involve external, objective surveyors who have a breadth of experience. One advantage of this type of system would be that, “After looking at all these departments, they’d come back with a broader perspective, and that would be a valuable resource.”

Can an increasing focus on accountability be leveraged to encourage LHD accreditation?

Panelists discussed the potential to link between accreditation and health outcomes measurement. While this has potential benefits, one person noted that there is a risk that improved ability to track outcomes could show that public health is not making a difference. A panelist remarked that she has worked in two state health departments, and thought they were both very well organized. Both states did poorly in nationwide, ranked comparisons of health status among their state populations, which made her wonder about the impact of public health efforts. She noted that one state where

she had worked had a very strong health department, while the department in an adjoining state “was in disarray.” Yet, “our state was ranked 43rd, and theirs was ranked 44th in the nation. It didn’t make much difference.”

One person said, “The easy gains have been made. I think public health is at a point where, if we make a difference, it is hard to count. The baseline is at a point where it is hard to measure. And it is harder to say we are the ones that make a difference.” Another person remarked that Healthy People 2010 relies on individuals to make changes in their health behavior. “The health department is only supposed to trigger and motivate such changes,” she pointed out. As a result, it’s difficult to demonstrate the outcomes of their efforts.

One panelist noted that it can be difficult to get policymakers to understand that long term goals may not be measurable over the short term. They are quick to cut funding due to a lack of immediate, measurable outcomes. Another panelist added that prevention data are difficult to demonstrate. He said, “You just have to wait for something bad to happen and get funded for that.”

While changes in health outcomes do take a while to emerge, another panelist pointed out, “You can look at indicators in the meantime that show you are moving toward the outcomes.” It was agreed that measurements should be taken at different points in time to ensure they demonstrate longitudinal changes. Arguing for the importance of having substantive measures, a panelist described the case of a tuberculosis outbreak in their county. They were able to tie it to a funding cut that had occurred two years earlier, when the Commissioner had eliminated two health department positions addressing tuberculosis. Funding for these positions was quickly restored.

Another panelist said his LHD had used tobacco dollars to conduct surveys; they now have data from three data points over a six year period. These datasets are useful to show how different interventions have affected various outcomes over the years. He emphasized that, when the LHD goes to the state with requests for funding, they need to be able to explain what they do, where the money has gone, and what difference it has made. Because of this, he said it is critical that the accreditation process be associated with measures of outcomes and/or processes. It was agreed that, as hard as it may sound, “one should try to link accreditation to improvements in services.”

Does the heightened interest in emergency preparedness create an impetus toward accreditation efforts among LHDs?

Commenting that funding streams drive LHD priorities, a panelist said that at his LHD, “60 to 70 percent of staff time is consumed by doing emergency preparedness.” He explained, “Money drives the system. The current system does not value the ability to assess problems locally. So if there is money to drive assessment that will drive accreditation.” Nonetheless, “Just dumping money is not going to work. There has to be structure that says, “This is how to use the money.””

One of the panelists suggested that if the dollars that have been attached to emergency preparedness planning are also linked to accreditation, LHDs would be willing to go ahead with accreditation. Another person said that their LHD had used emergency preparedness funding to build capacity, and felt that pursuing accreditation would not be out of line with this goal. However, a panelist reported that her LHD did not receive any funding for emergency preparedness. They used their own resources and time, and ultimately, “it was a lot of stress for the staff.” Drawing from this lesson, she concluded, “If staff members see accreditation as one more unfunded mandate, they will not buy into it.”

“Preparedness dollars have moved public health off center,” a panelist said. He felt that this new priority has been added to the workload of issues that the LHD has dealt with over the last thirty years. The urgency of the issue has created an environment where change is part of public health. Another panelist commented that, in his experience, “Public health will do anything that will have a positive impact for the clients.” Nonetheless he stressed, “The fact that you can do (a certain task) doesn’t mean that should be your role.” He felt that the system had become “so strained that it cannot take on anything else unless resources are there to implement it.” If resources were provided to support accreditation, he felt the department would “embrace it whole-heartedly.” Without that support, however, “any new initiative would add to the burden.”

Conclusions

Effect of Rurality on LHD Readiness to Pursue Accreditation

Most panelists said that efforts to develop consistent standards present unique challenges for rural LHDs. According to these individuals, rural health departments do not view accreditation as a priority, and their staff members are not bought into the concept. Panelists believed that specific characteristics (e.g., size, jurisdiction type, or population served) influence whether or not an LHD is able to meet accreditation standards. Capacity to meet standards is also shaped by an LHD’s level of access to funding and resources, as well as staff training and coverage.

Rationale for Seeking Accreditation

In discussing the benefits of accreditation, panelists returned repeatedly to the themes of enhanced capacity and improved quality of services. A number of panelists also felt that accreditation would bolster esteem for the role of public health—both in the community and among LHD staff. Some hoped that becoming accredited would better position LHDs to receive funding, while others were skeptical that this would be an immediate benefit. Some thought that accreditation could foster collaboration among stakeholder groups in order to meet standards.

The panel’s discussion of incentives and motivations for seeking accreditation suggested that funding would be a critical incentive and motivator for embarking on the accreditation process. Other incentives mentioned by the panelists included: enhanced capacity and performance; and improved communication about the role, functions, and accomplishments of public health.

Barriers to Seeking Accreditation

Inadequate staff knowledge about accreditation is a significant barrier, according to panelists. Yet staff members at LHDs may not necessarily be receptive to additional training on this topic. Often, they are not formally trained in public health, and therefore may not fully understand its mission. Shortages of other resources—including funding with which to carry out accreditation activities, were also viewed as problematic. Structural barriers mentioned included fragmented public health systems, siloed funding streams, a lack of credible data, and decision-makers who are not well-informed about public health issues and may see accreditation as a potential cost to the county.

Strategies Rural LHDs May Use to Become Accredited

Ideas that were discussed for stimulating LHDs to pursue and complete accreditation included: focusing on concrete results to be gained through accreditation; using innovative funding strategies to support accreditation; and creating a tiered or phased accreditation system (e.g., offering different levels of accreditation that would allow LHDs to build capacity over time). Panelists also believed it would be important to conduct training and education for staff members and local decision-makers such as county commissioners and boards of health. Finally, panelists talked about innovative ways to make the most of existing resources by using funding in new ways, forming partnerships with academic institutions and community based-organizations, and developing regional partnerships across LHDs.

Exploring what could be done to generate support for accreditation among staff, panelists offered suggestions such as linking accreditation to practice standards; indicating that the process could yield metrics for performance evaluation; and providing training and support to help staff members meet practice standards. LHDs should also be given tools to facilitate the accreditation process.

Engaging National, State, and Regional Partners to Pursue Accreditation

The panelists did not believe that rural health departments are being adequately represented in national efforts to roll out health department accreditation, and they varied in the degree to which they perceived that rural LHDs had been “at the table” for state-level accreditation discussions.

It was suggested that states may be able to champion certain standards to ensure that they are met throughout the state. When small rural health departments are unable to implement certain public health activities on their own, they may develop regional collaborations to ensure provision of these services. Yet, despite the potential benefits of regionalization, panelists noted that there can be obstacles in using this approach to pursue accreditation. Most notably, partnering implies giving up a certain level of local control, which may be a barrier among local decision makers.

Accountability and Other Factors Driving Accreditation

To be meaningful, accreditation should not be granted through a peer-review process, but should involve external, objective surveyors with broad experience. Panelists said the potential to link accreditation to health outcome measurement sounds like a benefit, but there is a risk that improved ability to track outcomes could show public health is not making a difference. While changes in health outcomes do take awhile to emerge, it was emphasized that short-term indicators can be used to provide evidence of progress toward outcomes. Commenting that funding streams drive LHD priorities, a panelist noted that, if resources were provided to support accreditation, LHDs would embrace it whole-heartedly.

5. Key Informant Interviews with State Officials

Introduction

The purpose of the key informant interview component of the study was to gain a state-level perspective on public health agency accreditation, with a focus on state support for accreditation efforts among rural LHDs, and accreditation-related issues specific to jurisdictions not served by an LHD. Key topics addressed during the interviews were:

- State health agency support for accreditation of rural LHDs;
- State direct provision of public health services in jurisdictions not served by an LHD and implications for state level accreditation;
- State contracting of local public health services and implications for public health agency accreditation; and
- Incentives and barriers to state health agency accreditation.

Methodology

Study Design

To assess state-level perceptions on public health agency accreditation efforts, NORC conducted a series of semi-structured interviews with current and former state health officials representing a variety of rural states. Specific areas of interest were state-level perspectives of rural LHD accreditation, incorporation of areas not served by LHDs into accreditation efforts, and perceptions of barriers and opportunities to state health department accreditation. The advantage of semi-structured interviews is their conversational nature. This flexibility ensures that critical topic areas and questions are addressed, while allowing unanticipated – but often important and relevant – topics to emerge. Interviews were conducted with eight state-level public health leaders (six current; two former).

In collaboration with NNPHI and CDC, NORC developed a protocol informed by initial discussion from the expert panel forum. The protocol was designed to glean common themes, provide insight into accreditation issues related to rural areas not under the jurisdiction of an LHD, state-level support for LHD accreditation efforts, and challenges and barriers to state-level accreditation. The protocol was developed to take 45 minutes to complete.

Two staff members from the NORC team staffed each of the interviews; a senior staff interviewer facilitated the interviews and a junior staff member was responsible for taking detailed notes and asking follow-up questions. A formatted version of the interview protocol was used for note taking and to analyze and summarize the qualitative findings included in this report. Protocols were reviewed by CDC and NNPHI and approved by NORC's institutional review board.

Selection of States

NORC worked with CDC, NNPHI, and the Association of State and Territorial Health Officials (ASTHO) to identify states that have rural areas not under the jurisdiction of a local health department. In order to select states that fit this criterion, NORC began by referencing the *State Public Health Law Assessment Report* by Lawrence Gostin and James Hodge⁴⁵ and the Public Health Foundation's (PHF) *Survey of Performance Management Practice Systems in States*.⁴⁶ The PHF report characterized the structure of state public health systems according to four categories: centralized; decentralized; mixed; and shared. In centralized systems local public health services are provided through units and/or staff of the SHA. In decentralized systems local public health services are provided through agencies that are organized and operated by units of local government. In shared systems local public health services are subject to the shared authority of both the state agency and the local government. And finally, in mixed systems local public health services are provided through agencies organized and operated by units of local governments in some jurisdictions and by the state in other jurisdictions. Gostin and Hodge merge the mixed and shared categories into a single "hybrid" category. In general, we felt that states with centralized and mixed structures would be more likely to have areas not covered by LHDs.

The Gostin and Hodge and PHF reports provided a good starting point for selection of states likely to have areas not covered by LHDs. Given inconsistencies between categorization schemes, however, NORC also consulted with CDC, ASTHO and NNPHI, finally selecting the following states to target for interviews: Maine, New Hampshire, New Mexico, Pennsylvania, South Dakota, Texas, Utah and Wyoming (see Exhibit 2).

⁴⁵ Gostin, Lawrence O., and Hodge, James. G. State Public Health Law Assessment Report. Washington: Turning Point National Program Office, 2002.

⁴⁶ Public Health Foundation. *Survey on Performance Management Practices in States: Results of a Baseline Assessment of State Health Agencies*, Washington. 2002.

Exhibit 2: Profile of Selected States

State	Gostin and Hodge (1)	Public Health Foundation (2)	% Rural (3)	Number of LHDs (4)
Maine	Decentralized	-----	59.8	2
New Hampshire	Hybrid	Decentralized	40.7	2
New Mexico	Centralized	Centralized	25	6
Pennsylvania	Hybrid	Mixed	22.9	16
South Dakota	Hybrid	Centralized	48.1	62
Texas	Hybrid	Mixed	17.5	112
Utah	Decentralized	Decentralized	11.8	12
Wyoming	Hybrid	Mixed	34.9	23

Sources: (1) Gostin, Lawrence O., and Hodge, James. G. State Public Health Law Assessment Report. Washington: Turning Point National Program Office, 2002. (2). Public Health Foundation. Survey on Performance Management Practices in States: Results of a Baseline Assessment of State Health Agencies, Washington. 2002 (3) Census 2000 Summary File 1 100% Data, P2, Urban and Rural. (4) NACCHO, National Profile of Local Health Departments. July 2006.

Study Participants

NORC sought the views of former and current public health leaders in states with rural areas not served by an LHD. Interviews were conducted with eight respondents that held a variety of different positions within their state agencies such as, public health director, deputy directory, senior deputy director and regional health officer. ASTHO provided NORC with contact information for key individuals (including former and current public health leaders) within the selected SHDs. Participants were sent an invitation asking them to participate in an interview. Follow up phone calls were placed to schedule interviews.

Respondents were employed by their state agency for an average of ten years. Half of the respondents served their state agencies for ten years or less; the minimal time employed was 3.5 years. Four respondents held positions within their state agency for greater than ten years. One of these respondents was employed by their state agency for 25 years. No respondents indicated they held previous positions in another state. However, several mentioned they held previous positions at the local level.

Study Limitations

It is important to note that only eight states were represented in this study; therefore, the opinions and thoughts of public health leaders in the remaining states were not captured. Additionally, within the states only one public health leader was interviewed; it is possible that the individual perceptions of interviewees do not reflect more broadly held views of others within the state.

Self-selection bias is another potential limitation of this study. Respondents' decisions to participate may have been a result of their strong opinions on health agency accreditation. It is possible that respondents who are strongly for or against accreditation were more inclined to participate. The findings of this research should be considered valid in representing the perspectives of participants, but can not be generalized to fully reflect generally held views and perceptions within each of the eight states individually.

Findings

In this section, we present findings from interviews conducted with current and former state level public health leaders. Results are organized by interview objectives: 1) State health agency support for LHD accreditation; 2) State direct provision of public health services in jurisdictions not served by an LHD and implications for state level accreditation; 3) State contracting of local public health services and implications for public health agency accreditation and; 4) Incentives and barriers to state health agency accreditation.

State Health Agency Support for LHD Accreditation

While all respondents noted that their respective states do not have an accreditation process in place for LHDs, four reported that their state has explored or is exploring LHD accreditation. Of these respondents, one cited working closely with another state (Washington) to develop strategies for improving the relationship between the state and local health departments. This respondent noted that many states do not have congenial relationships with local jurisdictions. As a result, when planning for LHD accreditation, the state of Washington was selected as a model because of the strong relationship between the state and local health departments within this state.

Another respondent mentioned that in the early stages of exploring accreditation, LHD staff did not embrace the concept. This respondent, from a state where local jurisdictions are given the option to develop an LHD, encountered the following situation when eliciting the thoughts of local staff toward accreditation: "I gave a speech at a conference held to get LHDs' thoughts on local public health department accreditation. Some locals expressed that accreditation may be the reason for counties to quit doing public health. They saw it as a stick without a carrot because they didn't have the resources to get accredited. They said they would quit doing public health and let the state take care of it. The concern was strong enough that CDC, who was present at the meeting, went back and re-thought their concept of the gold standard seal of public health department accreditation." Given the stark nature of this comment, it is important to note that the states included in our study tended to have state level authority of local public health services – that is, in contrast to states where there is a local jurisdictional requirement to provide public health services, it is ultimately the state's responsibility. LHDs, where they do exist, are "carved out" of this state system. In these

states, as noted by this respondent, LHDs may opt to dissolve and return local service authority to the state level if they are not adequately incentivized to participate in accreditation efforts.

When asked if their state would encourage LHD accreditation through a voluntary national accreditation system, two said their state would definitely support such an initiative. Most of the remaining respondents were generally supportive, but expressed some concerns. For example, some respondents said the autonomous structure of LHDs is a factor in whether or not the state agency will support local accreditation efforts. For example, one said, “The local health departments are ad hoc departments and have no partnership with the state. The state constitution gives authority to local health departments; therefore, I don’t know how much is possible, desirable, feasible and affordable.” Another added, “All of the local jurisdictions are in control of their own future and the state cannot tell them to do something. There are a lot of conflicts in decision making in terms as to what the state may even recommend to a locality.”

Two participants expressed uncertainty because local public health staff in their respective states are dubious of LHD accreditation. As stated above, LHD staff in one state (where LHDs are voluntarily established by local jurisdictions) expressed that an unfunded accreditation mandate might result in some LHDs deciding to cease operations. Even with funding tied to an accreditation initiative, this respondent felt some LHDs may oppose participation. The second respondent stated that locals in their state have been reluctant to discuss accreditation. However, this individual felt that monetary incentives could ultimately encourage locals to participate in the process.

Another two respondents felt a variety of factors would contribute to their states’ decision to support LHD accreditation. One of these respondents said a state-level champion to lead this initiative and additional funding would be necessary in order for their state to support the accreditation of LHDs. If given these resources, their state would be supportive because the initiative is in line their states focus on performance improvement and future strategic planning. Echoing this respondent, another mentioned, “There are several issues that would need to be addressed for our state. The important thing would be a process that would allow people to be able to do this relatively easily and it would have to be accessible, feasible, and affordable in the context of our state.”

State Direct Provision of Public Health Services in Jurisdictions not Served by an LHD and Implications for State Level Accreditation

State Health Department Staff Support for Local Services

Most respondents from states with regions not covered by LHDs reported that SHD staff assist in providing services to these areas. The nature of these services varies by state. For example, one respondent said public health nursing officers are set up in counties that do not have local health departments. The number of public health nurses stationed in these areas varies by the population of the county. There are public health nursing managers at the state level to oversee these individuals. Two respondents said SHD staff assist in providing specific services (e.g., nursing, food protection, radiological health) in rural areas not covered by LHDs. One of these respondents emphasized that, in addition to providing services to rural areas not covered by a local health department, state staff also assist in areas with an LHD presence. Two respondents noted that field offices, staffed by state employees, are set up to provide services at the local level.

Two respondents noted the infrastructure of their state is regionalized and thus regional health departments are responsible for covering areas that are not supported by local health departments. However, one said that, due to limited resources, regional health departments are only able to focus on disease monitoring and outbreak surveillance for these areas. Regional health departments are also responsible for supporting LHDs that need help in the event of an emergency or natural disaster. Only one respondent said that state staff do not assist in providing services in areas not covered by an LHD. This individual noted that contracts with local providers are used to supply services in these areas.

Tools to Assure the Quality and Consistency of Local Public Health Services

Few respondents reported using a specific tool or product to assure the quality and consistency of public health services delivered to local jurisdictions not covered by an LHD. One respondent commented that their state uses national performance standards to assess the provision of services. Additionally, this respondent reported having used the NACCHO Mobilizing for Action through Planning and Partnerships (MAPP) tool. Another respondent noted that their state developed their own tool for quality assurance purposes. However, this individual commented that the developed tool was not “rigid” and the protocols used changed over time. This tool was used to collect information from health centers in the counties without a LHD. Another participant emphasized that quality of control mechanisms used to monitor local public health services varies by public health program. For example, programs focused on service delivery are closely monitored by processes such as chart audits, immunization audits and customer feedback surveys. It was also mentioned by one participant that although their state does not use a particular tool or product to measure the quality of services delivered to areas not served by a LHD, quality assurance is enforced as a result of statutory and contractual requirements.

Perceived Implications for Accreditation

Respondents were asked to provide recommendations for how state level accreditation efforts can incorporate services that might otherwise be provided by LHDs. All but one of the respondents felt state health departments that provide services otherwise provided by an LHD should be held to LHD accreditation standards. One respondent summarized the thoughts of the others when they said, “If they [the state] are providing services to local communities, the state should be held accountable because they are supposed to follow the ten essential services. There should be an accountability mechanism in place for the public.”

One individual suggested that standards at the state level should accommodate potential field work conducted at the local level. However, this individual felt that although states should be cognizant of local needs, having the same set of standards for state and local public health agencies may not fit the environment of all states. This respondent went on to say, “A lot of people in our state don’t understand local public health. Trying to explain local public health is difficult. If you have national standards that you can use to show others, then they will get it.”

Though not entirely inconsistent, the remaining individuals suggested that the same set of standards, broad and relatively straight forward, be used for state and local health department accreditation.

State Contracting of Local Public Health Services and Implications for State Level Accreditation

Contracted Partnerships for Local Services

Respondents noted that their states contract with local partners, such as hospitals and non-governmental organizations, to provide local public health services. Two respondents mentioned all, or most, of the local public health services in their state are provided through contracts. One said, “We have a tremendous amount of contracts and a lot of [the state’s] resources are just dedicated to contracts management. We don’t have enough money for state wide coverage and are using the jurisdictions to identify agencies that might be used to coordinate and plan for service delivery.” The second respondent mentioned their state was working to coordinate services under a regionalized governmental public health system, but as of now, contracts are used by the state to provide services in local areas.

Three respondents said that some services at the local level are provided through contracts. For example, one said community organizations in their state provide maternal and child health services at the local level. Another echoed this respondent and reported, nursing, HIV/AIDS, maternal and child health and environmental health as services provided through state contracts at the local level.

Among the remaining respondents, two said only a few local public health services are provided by contractors. One said, “If we do contract with locals, we expect them to meet certain standards.” Examples of contracted services that are provided at the local level include cancer screenings and health services for children with special needs. The second respondent noted that their state contracts out programs for tobacco cessation, mental health and substance abuse services. One respondent did not specify the degree to which contracted services are used to provide local public health services.

Tools to Assure the Quality and Consistency of Local Public Health Services

On the whole, respondents noted their states do not actively monitor the quality and consistency of public health services delivered to areas not served by an LHD via contractors. One said their state does require accountability for contracted services, but does not specifically monitor whether or not contractors are meeting standards. In order for contractors to receive payment, they are only required to meet with state department staff on a regular basis and provide a status update. The state has discussed enforcing performance based measures, but little progress has been made in this respect. Likewise, another individual said their state has discussed “service level contracts” which would require measures (above and beyond structure and procedural measures) to be developed and met by each contractor. The state did not pursue this idea because resources were not available for enforcement of these contracts and traditional contracted activities provide no flexibility in programming.

Perceived Implications for Accreditation

In contrast to respondents’ thoughts on SHD department accountability for services provided at the local level, respondents were less certain whether local partners that provide these types of services should be held accountable for local accreditation standards. Three individuals favored holding local partners accountable for local standards. Of these respondents, one noted strong communication

with contractors is essential and that a designated authority at the state level should be responsible for ensuring local standards are met by contractors.

Two other respondents expressed that whether or not local partners should be held accountable for local public health standards is dependent on the type of service. For example, one respondent noted their state may be supportive of local partners being held accountable for accreditation standards focused on clinical services. However, this individual said, “We don’t and won’t have control over all local partners.” The second individual emphasized a definition of the specific public health services would be necessary to determine whether or not local partners should be held accountable for LHD accreditation standards.

On the other hand, two respondents reported that holding partners to local accreditation standards would be especially problematic in their states. One respondent stated that state officials would argue as to whether or not non-government agencies should be held accountable for these standards. Another said that as a result of the relative lack of resources and public health workforce, their state is currently struggling with employing local staff to provide these services. If the state required contractors to be held accountable for LHD standards, members of the public health workforce may refuse to become contractors of the state, leaving these areas without partners to provide essential services.

Six respondents provided recommendations for how state level accreditation efforts can incorporate contracted services that might otherwise be provided by LHDs. Two respondents made recommendations on each of the following topics:

Quality Improvement Process - In regard to developing a quality improvement process/assessment for contracted services, one respondent mentioned their state adopted a score card that was used to assess direct and contracted services. Although this assessment process lost momentum when the champion of this initiative left the SHD, this respondent felt a basic generic quality improvement process could be used to determine if contractors are meeting standards. Another respondent emphasized this suggestion, but informed us that their state has been somewhat unsuccessful at enforcing specific requirements of contractors due to limited resources.

Education – One respondent noted that education is the first step to enforcing local partners be held accountable for LHD accreditation standards. This respondent mentioned that many contractors are not knowledgeable of local public health and accreditation. Likewise, another participant felt that using standard, basic terminology when developing standards would help to educate those not conversant in public health language.

Reference Standards in Contract – One respondent said in order to enforce contractors’ compliance with LHD accreditation standards, their state would reference the standards in contracts with these providers. Partners would be required to report back relative to the standards. Echoing this, another respondent said, “As a general rule, our state doesn’t accept lower standards from contracted staff as compared to our salaried state employees.”

Status of State Health Department Accreditation

Exploration of State Level Agency Accreditation

When asked if their state has explored state level agency accreditation, all respondents answered positively. However, the degree to which states have explored this initiative varied. For example, one respondent mentioned that their state is actively exploring state level agency accreditation and said, “To get ready for accreditation is our ultimate goal. We explored accreditation before we knew it was a formalized movement in the nation. We would like to use accreditation to develop performance standards and quality improvement measures.”

Another respondent mentioned their state was involved in the early dialogue around state agency accreditation. To explore the possibility of state agency accreditation, the state department engaged stakeholders to create a guidance document that would be used to complete an assessment of the SHD. However, in 2003 SHD priorities shifted because of a departmental re-organization and new focus on emergency preparedness. As a result, this respondent, a former state employee, said “These two things kept us from doing what we would have liked to in terms of accreditation. I don’t know if things have moved forward since then.”

A third respondent agreed with these respondents and mentioned that their state has been exploring state agency accreditation for a while. This respondent noted that their state has examined accreditation efforts of other states and has focused on relationship development at the state and local levels. Regardless of these activities, this respondent felt their state was still far from the development of a process or model that could be used for accreditation. Similarly, another respondent noted that their state health department had explored the issue (which included attending an ASTHO meeting on this topic), but has not made any additional progress.

Four respondents noted their respective states have more recently begun to discuss public health agency accreditation. One respondent mentioned the director of their SHD recently met with senior management to discuss implementing a state tool to examine strengths and weakness of the SHD and to brainstorm possible quality improvement measures. This informant also mentioned that their SHD participated in an accreditation workgroup hosted by the state prevention institute and created tools around the ten essential services for local health departments (although it was noted that local health departments were not receptive to these tools). Additionally, this respondent said their state is at the cusp of making a public statement in support of accreditation. Another individual held a similar perspective and mentioned their SHD has discussed how accreditation will play a role in strategic planning and future directions.

Both of the remaining individuals said that there have been accreditation discussions at the state level, but little progress has been made to embrace the initiative. One said, “I think it has been discussed and that is about as far as it has gone. It’s like one of those projects where if you are going to do it, you need to assign someone to the project. But to the best of my knowledge there hasn’t been solid advancement in the area.” The other suggested discussions have not moved to the next level because their state is dubious that the accreditation of their state health agency will not be possible without additional resources.

Strategies for State-Level Accreditation

Three respondents suggested regionalization as a method for expanding public health services available to local jurisdictions; four recommended a multi-level approach to accreditation; and one

suggested the inclusion of other state departments that may provide public health services as part of an expanded state-level accreditation process. Specific strategies included the following:

Regionalization – In general, regionalization was mentioned by respondents as a possible strategy for streamlining public health services. One respondent, in support of regionalization, said that their state is actively looking into this option. This respondent said, “There are fiscal issues, but the idea is to develop a regionalized effort/system. We are currently exploring the best ways of doing so. We are considering decentralization (of public health services). It is a gradual process and no boundaries have been defined yet.” Another respondent mentioned that their state has actively explored regionalization for several years and has charted the possible locations of regional units of the state health department. This individual’s perspective was somewhat unique, however, in that the state was seeking to regionalize county level offices run by the state into regional offices run by the state. The motivation was not decentralization, but rather an attempt to create efficiencies in state-level service provision in light of anticipated funding constraints.

Multi-Level Approaches – One informant suggested that accreditation should consider three levels of services: 1) local public health services, 2) state public health services, and 3) local public health services provided by the state. This respondent felt that a state level accreditation initiative should include a separate component for states that provide local services and that such states should have an option for secondary accreditation of these services. Another respondent expressed a similar opinion, stating that accreditation efforts should include a multi level approach that considers central services provided by the SHD (such as program management and monitoring) separate from field services provided by state department staff. A third emphasized a multi-level approach focused on clinical services and another felt that the services that assist the most people (immunizations and family planning in the case of this state) should be included in the first level of a multi-level accreditation initiative.

Inclusion of Other State Departments - One individual mentioned that, for their state, an SHD accreditation initiative should include an accreditation process for other state departments that provide public health services. For example, in their state the Department of Agriculture provides restaurant and food packaging inspections for this state.

Incentives and Barriers for State Health Department Accreditation

In discussing incentives and barriers for state agency accreditation, most respondents agreed that there would be differences in how these apply to larger and more urban states versus smaller and more rural ones. However, few were able to provide specific examples of *how* incentives and motivations would differ. One respondent mentioned that it is more challenging for rural states due to more limited resources. Another challenged this statement and felt that it would be easy for their state to define a process for accreditation because, unlike larger states, it is easier to come to an agreement with fewer public health staff. A third explained there are differences in both incentives and barriers because rural states are more dependent on federal funding and have higher per capita expenses, while urban states have a more solid tax base that can be relied upon. This, it was felt, changed the dynamics in terms of federal incentive funding, as well as the abilities of rural states to meet standards.

Incentives

Most respondents mentioned funding as an incentive to seeking state health department accreditation. Additionally, the following incentives were mentioned by several respondents: quality improvement; national recognition; relationship building; workforce recruitment; and educating policy makers and the community. The alignment of standards as a result of an accreditation initiative was mentioned as a benefit by one respondent. Incentives discussed by respondents are organized by topic:

Funding - Respondents were enthusiastic about the possibility that the accreditation of SHDs would be linked to funding. One respondent summarized the thoughts of others when they said, “CDC, HRSA and other funding bodies could encourage accreditation by requiring accreditation as part of the funding process” Two respondents felt accreditation could be used to even out the playing field in terms of federal funding. Several said the concept of accreditation and quality improvement would be helpful in speaking with legislators and policy makers to secure additional funding. One felt that state health agency accreditation could be used to leverage money from foundations, but not necessary from the federal government. A specific suggestion on how to link accreditation with funding was provided by one individual: “When I talked to CDC number of years ago, there was a discussion going on about giving states 80% of current funding and taking the remaining 20% to give to accredited states. Such strategy could work.”

Quality Improvement – Several respondents felt that accreditation for SHDs would lead to an improved delivery of public health services. One said, “There would be gains in terms of quality improvement because the state would be able to apply for various grants from foundations to work on quality improvement and the community would feel more comfortable knowing that some set of standards is being met.” Respondents felt accreditation would create a built-in quality improvement process that would be used to enhance the delivery of services.

National Recognition – Two respondents said the accreditation of SHDs would result in national recognition for the field of public health. Respondents mentioned that this type of recognition could be used in many different fashions, such as leveraging funding and local and state-level advocacy. One of these respondents mentioned, “We fancy ourselves as leaders, early adopters and innovators. Accreditation would allow us to demonstrate this to the community. Regionally, this may help us show that we are better than other health departments and push us to compete with our peer groups.”

Relationship Building – Respondents discussed using accreditation to build relationships with federal agencies, foundations, academicians, and within the community. For example, one mentioned that state agency accreditation may help their state to foster relationships with academia and build research capacity. In addition, one mentioned that accreditation would help strengthen the relationship between the state health department and their partners because it could be used to promote their accountability.

Workforce Recruitment – Two respondents mentioned that SHD accreditation would help to attract and expand the public health workforce. As expected, these individuals mentioned that their states struggle with staffing and felt that a national accreditation effort would contribute to the advancement and enhancement of the public health workforce. One felt that individuals would be encouraged to work for state and local agencies adhering to performance measures.

Educating the Community, Policy Makers and Partners – Respondents discussed that SHD accreditation would increase the knowledge of public health, both among policy makers, public health partners, and within the community. One said, “The tool (accreditation) presents us with a ready made vehicle for explaining ourselves.” Another noted that an accreditation initiative could be used to educate the community, as well as public health partners and policy makers. For example, this individual said, “Public health is not understood by other components of state system. We have a tremendous number of folks who do not embrace the concept of public health, don’t know what we do, don’t understand population health and don’t understand health as a public good. This would help us to communicate and educate other people to see that they have a relationship with public health – for example, the agricultural sector.” It was also suggested that comparing health departments using accreditation data may help the community to better understand public health and the impact of accreditation on the community.

Aligning Standards - One respondent stressed that an accreditation initiative would be beneficial for SHDs because it would help to align multiple standards required by different funders. This individual said, “If you are an agency that overlooks all these smaller agencies, it makes sense to have standards to adhere to. There are federal sources of funding that require the fulfillment of certain standards. An accreditation system would be an umbrella standards system over many partners who enforce standards on us.”

Barriers

Limited fiscal and human resources, leadership and legislative barriers were most often mentioned as obstacles associated with state agency accreditation. Several respondents mentioned that the specificity and rigor of accreditation standards may also be a challenge and that state level accreditation may have a limited impact on the community. One respondent did not report any barriers, and said, “Although there would be some individuals that would challenge the system because this would be a change, overall I do not think there would be barriers. I know much of the staff and to me that is a plus because I could present accreditation in a positive way and we would come to a consensus fairly quickly.” Two respondents noted that they felt that stakeholders and officials may not pursue accreditation wholeheartedly if it is a voluntary initiative or if it is not attached to very strong incentives (i.e., funding). These participants stressed that SHD accreditation may not grow to reach its full potential unless one or both of these criteria are met. To support this thought, one said, “There has to be something for people to sink their teeth into (e.g., higher salary or more grant money). There should be some ongoing recognition that is obvious and available to people when they seek it.” Barriers discussed by respondents include:

Limited Fiscal and Human Resources – Some respondents felt that their state would face barriers in pursuing accreditation due to limited fiscal and human resources. For example, one said, “If we could do it [accreditation] right now and it wouldn’t cost the state any money that would be one thing, but that is not the case.” Other respondents stressed that funding for public health is decreasing each year and additional requirements are being placed on health departments. One described the tradeoff that many state agencies may face if they pursue voluntary accreditation as such: “It costs money to do these things. States that have done well and have accreditation in place have gotten huge amounts of funding. The biggest barrier is the fact that if you do accreditation, you have to take money out from other services and redirect that into accreditation.”

Leadership– Respondents provided two different perspectives on leadership barriers associated with state health agency accreditation. First, respondents mentioned turnover of leadership as a barrier because leadership may have different ideas on how to implement resources and turnover is frequent within the public health workforce. Secondly, respondents stressed the importance of an “accreditation champion” at the management level to drive the mission and vision of accreditation. Without this type of champion, respondents felt their state would be unable to gain the buy-in required to successfully pursue this effort.

Legislative Barriers – Some respondents mentioned that their state may encounter barriers among state elected officials. On the whole, respondents reported that many of their legislators are not knowledgeable about public health and do not understand the concept of evidence based public health practice. Often legislative staff are focused on the allocation of state resources, largely based on specific funding silos, and may lack interest in accreditation and quality improvement processes. One of these respondents noted that factsheets and materials would need to be developed in order to educate legislators on how SHD accreditation relates to outcomes at the legislative district level.

Specificity and Rigor of Standards – One respondent said the primary barrier to SHD accreditation would be whether or not their state would be able to achieve accreditation. This respondent questioned, “Will accreditation be tight so that only a few will be able to achieve it?” Another respondent stressed, “one-size does not fit all” and went on to say, “Using the JACHO model for hospital accreditation will not work because public health services are different and variant, unlike hospital services.” How to develop standards that cover diverse public health services and persuade states to be held accountable for these standards will be a challenge. One respondent emphasized that accreditation should be based on objective criteria that can be applied across states.

Limited Impact on Citizens – Some respondents felt that accreditation may not have a noticeable impact on the health of citizens, creating difficulties in justifying accreditation efforts. One respondent recalled that state decision makers did not pay attention to emergency preparedness until events such as Hurricane Katrina and Pandemic Flu. This individual felt that accreditation may follow a similar pattern and not become a focus due to the lack of a sense of urgency. Another individual provided the following example to support their view on this potential barrier: “I don’t know if accreditation will make that much difference for people not in public health. I don’t think the majority of people know what public health is, let alone what accreditation would do for them. I spent most of my career as a clinician and I can’t ever remember being asked if the hospital I worked for was JACCHO accredited or if I was board certified. You would have to get the word out about accreditation and educate people that might be affected one way or another – which would be a challenge.”

Conclusions

Exploration of State Level Accreditation

Public health agency accreditation has been explored by all states represented in this analysis. The degree to which states have explored this initiative varied. All respondents noted that their

respective states do not have an accreditation process in place for LHDs. Several states have explored the possibility of LHD accreditation, however most respondents expressed uncertainty about whether their state would encourage LHD accreditation through a voluntary national accreditation system.

State Direct Provision of Public Health Services and Implications for Accreditation

Most respondents reported state agency staff assist in providing services to regions not covered by LHDs. A multi-level approach to accreditation was suggested for these states, focused on 1) local public health services, 2) state public health services, and 3) local public health services provided by the state. Most respondents also felt that states with direct responsibility for local jurisdictions should be held accountable to LHD accreditation standards.

State Contracting of Public Health Services and Implications for Accreditation

Respondents collectively confirmed that their states contract with local partners to provide local public health services. Recommendations for how state level accreditation efforts can incorporate contracted services include: a quality improvement process/assessment to monitor contracted services; educating contractors about local public health; and including local accreditation standards in contracts with local partners. In comparison to respondents' thoughts on SHD accountability for services provided at the local level, respondents were less certain that local partners that provide these types of services could be held accountable to LHD accreditation standards.

Incentives for State Health Department Accreditation

Most respondents mentioned funding as an incentive to seeking state health department accreditation. Other incentives that were discussed include: quality improvement; national recognition; relationship building; workforce recruitment; and educating elected officials and the community.

Barriers to State Health Department Accreditation

Limited fiscal and human resources, leadership, and legislative barriers were most often mentioned as obstacles associated with state agency accreditation. Several respondents mentioned that the specificity and rigor of accreditation standards may also be a challenge. A final barrier noted by respondents was that state level accreditation may have a limited impact on the community, making it hard to justify among policy makers and community members.

6. Overall Study Findings

The study drew from a number of sources, including a review of literature, an expert panel discussion with leaders from eleven rural, local health departments (LHDs), and key informant interviews with eight leaders from state health departments (SHDs). The purpose of this research was to enhance understanding of how public health infrastructure may influence the attitudes and actions of rural public health departments with regard to seeking accreditation.

Accreditation has been identified as a potential strategy for strengthening the public health system. Proponents suggest that a comprehensive national accreditation effort may help to reduce variation both across and within states (i.e., at the county and local level) in public health services offered. To date few studies have been published on the implications of accreditation for small and rural public health agencies. This study's review of the literature and discussions with representatives of rural LHDs (N=11) and SHDs (N=8) provides valuable insights into why state and local health departments that serve rural areas have sought or will seek accreditation; how those agencies are likely to approach accreditation; incentives and barriers to accreditation; and strategies for approaching accreditation.

Although progress has been made in developing strategies for accrediting public health agencies in general; there is a dearth of information on how this is affecting health departments serving rural areas. Rural localities differ substantially from urban areas in terms of its infrastructure, population and geographical characteristics, and culture. For these reasons, approaches to accreditation that are applicable in urban areas may not be appropriate to rural agencies. A number of salient themes emerged from the expert panel meeting and the state level interviews, as described below:

Motivations and benefits of seeking accreditation. Accreditation can be a tool to communicate the functions of public health by delineating its responsibilities and clarifying its role to the community. Educating the public, staff and other stakeholders is especially important as the purview and responsibilities of LHDs continue to expand. Accreditation could also be used to demonstrate the benefits of public health to county commissioners, board of health members, governors, and other state and local policy makers, in order to leverage and/or sustain funds for public health activities. In addition, accreditation could foster interaction among stakeholders, encouraging collaboration to meet high standards, avoid duplication of efforts within communities, and maximize returns from scarce resources.

Both state and local participants in this study noted that accreditation standards could help LHDs to assess their work and identify areas for improvement. Using accreditation as a vehicle to build capacity also emerged as one of the motivators in the discussions with the local and state health officials. Many saw this as an opportunity for rural jurisdictions to address workforce issues by encouraging trainings and collaborations with partners.

While it was acknowledged that public health agencies that are responsible for rural jurisdictions are likely to face unique challenges in achieving accreditation standards, they may also have unique motivations for seeking accreditation that can be enhanced through appropriate efforts to incentivize the process. Having accreditation as a funded mandate or having designated funding for

accreditation would be a motivation for LHDs, especially for small, rural LHDs that have insufficient resources to undertake such activities.

Benefits of accreditation that were cited by LHD and SHD respondents included the possibility of funding tied to accreditation; quality improvement and streamlining of public health services; recognition for the field of public health; opportunity to collaborate with federal agencies, foundations, academicians, among others; and creation of a rigorous and accountable work environment conducive to professional development and recruitment of competent workforce.

Both the state officials and local health department representatives said accreditation could be beneficial in terms of developing local partnerships and gaining recognition among community organizations. However, a small number said that in rural areas, credibility is all about personal relationships. “The seal of approval” implied by accreditation, therefore, may not have much value.

The panelists and the state officials agreed that because all agencies would be required to adhere to certain standards, accreditation may be linked to enhanced capacity and improved quality of services. Some were also positive that accreditation would promote uniformity in the quality of services delivered across health departments. Accreditation can further be used to monitor agencies’ performance and document outcomes for strategic planning and quality improvement initiatives. Moreover, most LHD panelists and SHD respondents believed accreditation efforts may improve their ability to leverage funding; only some LHD respondents expressed some uncertainty.

Barriers to rural public health agency accreditation. Limited fiscal and human resources, lack of awareness of accreditation among decision-makers, leadership and legislative barriers are oft-mentioned obstacles associated with public health agency accreditation. There was a strong consensus among the rural panelists and key informants that a lack of adequate funding is the major barrier to seeking accreditation, especially with the tapering off of federal funding each year. The panelists expressed frustration at the paucity of grants directed to small agencies, and noted that the limited amount that makes its way to the local level is often “siloed” for specific conditions or diseases. Difficulty in securing buy-in from stakeholders is another barrier which emanates from the lack of immediate and concrete benefits of accreditation. No distinct link has yet been established between accreditation and quality of care.

Many were reluctant to consider redirecting funds from services to accreditation efforts, and others felt that without strong incentives or immediate, tangible benefits to pursue accreditation there will not be much interest among stakeholders. Some also voiced their concern over leadership turnover and the absence of *champions* advocating for accreditation in public health agencies. The rural panelists went on further to express that staff members in their LHDs were not completely on board with the idea of accreditation because LHDs with fewer staff may feel more apt to spending limited resources on service delivery than on assessments.

In addition to resources, another significant barrier that was identified is standards development and problems of collecting consistent, accurate data. Setting uniform standards for public health agencies that are so diverse in infrastructure is a “Herculean task,” as one panelist put it, and one size certainly does not fit all. Study participants voiced concern over finding an objective set of criteria that could be applied across states and across fragmented public health systems within states. Expert panelists and state leaders also felt that the development of consistent standards poses a unique challenge to rural LHDs as compared to urban ones. They mentioned that accreditation may

not be as much of a priority in rural communities because of variations in access to funding and resources. In addition, the variance in the nature of services delivered in rural jurisdictions and substantial services being contracted out to local partners were noted as inhibiting factors.

Potential approaches to rural public health agency accreditation. Both the panelists and state informants were in agreement when they said that designated funding for accreditation would be critically important, both for motivating local and state health departments to pursue it, and for paying for the resources LHDs would need to become accredited. Demonstrating the value of accreditation to local decision-makers early on to secure their buy-in was also mentioned as critical.

Participants stated that an accreditation effort tied to funding would allow them to pursue a variety of strategies based on the public health infrastructure and needs of their respective states. Panelists and state interviewees suggested regionalization, tiered or multi-level approaches, inclusion of public health partners in accreditation efforts, and training of the public health workforce as possible approaches to advancing public health agency accreditation. Half of the state interviewees advocated for a multi-level approach to accreditation (i.e., an approach focused on distinct levels of services such as local public health services, state public health services, and local public health services provided by the state). A similar idea was also raised repeatedly over the course of the panel discussion. The panels recommended a “tiered” process that would involve applying different standards to different LHDs based on the specific services they provide, as opposed to requiring all LHDs to meet one rigid set of standards. For states that contract with local partners to provide local public health services, states could incorporate in their contracts an assessment to monitor contracted services, and educate contractors about public health and accreditation standards.

Regionalization was also noted as a potential strategy. In the discussions, regionalization was conceptualized in two different ways: (1) as the establishment of a regionalized public health agency across multiple jurisdictions; and (2) as a formalized collaboration between multiple, independent public health agencies. Regional collaboration or regionalization is often used to implement public health activities that cannot be achieved by small rural health departments on their own. Regionalization can be a potential strategy for creating a “critical mass” of resources necessary to deliver public health services that meet accreditation standards. Regionalization increases the level of technical resources available to public health agencies and facilitates the development of networks and the sharing of resources across counties.

Based on these themes, we offer the following findings:

Finding 1: Efforts to develop consistent standards present unique challenges for rural LHDs.

Rural public health systems differ from urban systems in terms of workforce capacities, infrastructure, diversity of population served, and funding, among others. LHD panelists and state public health leaders both noted that the organization of the state’s public health system can influence whether or not an LHD has the motivation and capacity to meet accreditation standards. The potential benefits of voluntary accreditation programs may be more difficult to foresee in rural areas given the wide variance in rural public health infrastructure and the kinds of services delivered in those areas. Further, study participants noted that public health infrastructure in much of rural America is weak and it may take more effort and resources for rural LHDs to meet accreditation standards than their urban counterparts.

Finding 2: Accreditation can be a tool to communicate the functions of public health by delineating its responsibilities and clarifying its role to the community and stakeholders.

Educating the public, staff and other stakeholders on what public health is all about is important as the purview and responsibilities of LHDs continue to expand. Accreditation could be used to communicate the benefits of public health to county commissioners, board of health members, governors, and other state and local policy makers in order to leverage and/or sustain funds for public health activities. In addition, accreditation could foster interaction among stakeholders, encouraging collaboration to meet high standards, avoid duplication of efforts within communities, and maximize returns from scarce resources. Given the fragile nature of the rural public health infrastructure and the greater dependence on state and federal pass through resources, these education efforts were deemed even more critical in rural areas.

Finding 3: Improving capacity and quality of services are perceived as key benefits of accreditation.

Both the state officials and LHD representatives agreed that because all agencies would be required to adhere to set standards, accreditation could lead to improved quality of services, while setting a bar for health departments to achieve certain capacities. Some were also optimistic that accreditation would promote uniformity in the quality of services delivered across health departments. Accreditation could further be used to monitor agencies' performance and document outcomes for strategic planning and quality improvement initiatives. Moreover, some suggested that accreditation could enable them to more effectively compete for more grant money from governmental and non-governmental sources. Given the lack of uniformity across public health agencies in general, and rural agencies specifically, efforts to demonstrate consistency in public health services was seen as important to rural health departments.

Finding 4: Inadequate fiscal and human resources were identified as major barriers associated with health department accreditation.

Barriers to accreditation reported among rural LHDs included inadequate staff knowledge of accreditation; lack of formal public health training among LHD staff; shortages of resources; and structural barriers, such as siloed funding streams and fragmented public health system. There was a strong consensus among the panelists and state key informants that lack of adequate funding is the major barrier to seeking accreditation. Panelists and interviewees expressed frustration at the paucity of grant funds directed to rural agencies, and noted that the limited amount that reaches the local level is often marked for specific conditions or diseases. Inadequate staff knowledge about accreditation was cited as another impediment to rural health departments actively pursuing accreditation. This problem emanates from workforce issues faced by LHDs in general (e.g., lack of public health education), that are often even more prominent in rural areas.

Finding 5: Multi-level or tiered approaches should be considered as potential strategies for implementing a national accreditation system.

Both state and local level participants recognized the disparate nature of public health systems cross the country and suggested flexible, inclusive approaches to accreditation. At the state level a "multi-level" approach to accreditation was envisioned. This approach was seen as having distinct accreditation standards focused on: public health services provided locally, public health services

provided at the state level (e.g., centralized management activities), and local public health services provided by the state (to address the issue of SHDs providing services in local jurisdictions not served by LHDs). Alternatively, a few key informants believed that SHDs directly responsible for providing local public health services should not be held to a different standard, but should rather be held to the same standards as LHDs. Similar discussions were also held among LHD participants, who suggested a tiered approach to accreditation. A tiered system would involve applying different standards to LHDs based on the specific services they provide, as opposed to requiring all LHDs to meet one rigid set of standards. It was felt that this could provide a means of creating an inclusive accreditation system, whereby “limited service” LHDs could be accredited only for the services they provide, and not penalized for those that they do not provide.

Finding 6: Educating health department staff and policy makers are key strategies for rural LHD accreditation.

In addition to the core recommendations on implementing accreditation at the national level, participants also provided concrete recommendations for local level implementation. These included educating health department staff about the rationale and benefits of accreditation and demonstrating the value of accreditation to county commissioners and mayors who may otherwise see it as an unfunded mandate. Participants noted that, particularly in rural health departments, staff are not educated in public health and are therefore less likely to understand the benefits of accreditation. Local policy makers are likely to have an even more limited understanding of public health and further, have the responsibility of balancing multiple community needs. This may limit the level of priority placed on public health among policy makers, who may otherwise see issues such as accreditation as an added burden. Educating both staff and policy makers regarding the potential value (monetary and otherwise) of accreditation is critical in implementing efforts in rural communities

Appendices

Appendix 1: Pre-Panel Questionnaire



The National Opinion Research Center (NORC) has been contracted by the National Network of Public Health Institutes (NNPHI) to convene a panel for examining the motivations and approaches of rural health departments relative to voluntary agency accreditation. In order to facilitate this project, we are asking all potential participants to complete the following form to help us understand your experience with voluntary accreditation. We are seeking participation from persons with a broad range of attitudes and experiences with voluntary accreditation so please be candid with your responses. If you have any questions regarding this project, please contact the project director Michael Meit, at (301) 951-5076 or meit-michael@norc.org.

Your Name

Email address:

Primary phone:

Name of Health Department

Address

City, State, zip

County(s) served

Name of Director/Commissioner (if different from above)

Contact information (phone/email)

Size of Population served by health dept.

Makeup of population served.	%	
		Asian
		Black or African American
		Pacific Islander/Native Hawaiian
		White

Total # of Staff Employed by Health Department

Is your primary population served Urban Suburban Rural

2) How familiar are you with voluntary accreditation of health departments?

Very familiar	Familiar	Somewhat familiar	Not very familiar	Not at all familiar
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3) What is the driving force behind your interest in accreditation?

	Highly important	Somewhat important	Not at all important
A mandate from the state or a state-level agency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feedback from a departmental capacity assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regionalization efforts in my area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased community/political pressures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promotion of public health quality improvement standards in the community that my department serves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My understanding of the utility of accreditation in assuring public health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4) Is accreditation of local health departments mandatory in your state?

Yes	No	Don't Know	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5) Is your health department currently accredited?

Yes	No	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6) Please select the corresponding box that best matches your experience with accreditation?

	Very familiar	Somewhat familiar	Not very familiar
Public Health Accreditation Board (PHAB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strategies for pursuing accreditation in LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conducting capacity assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NACCHO's Operational Definition metrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal aspects of accreditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation communication/dissemination strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regionalization of services as an approach to achieving readiness for accreditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Existing incentives for pursuing accreditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facilitating/participating in peer networks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7) Please check the box that most closely matches your experience/opinion with voluntary accreditation for local health departments. *(Your responses to this question are solely for the purpose of helping us select a broad array of participants for this panel and will not be made public or used in any of the products resulting from this project.)*

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Accreditation will benefit my health department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation will lead/has led to changes in the function or operations of local health departments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation will help/has helped to improve the quality of the services provided by LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation assessments require allocation of resources that could be more effectively used elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The process is useful to identify gaps in public health services provided by LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rural LHDs will have a more difficult time meeting accreditation standards due to resource limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accreditation standards focused on agency-level operations are the most beneficial for LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The requirements of rural LHDs are significantly different than those of more urban LHDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The development of voluntary accreditation standards for LHDs should take a bottom-up approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 2: NACCHO's Use of RUCA Codes to Classify LHDs

The Rural-Urban Commuting Area (RUCA) system is one of several ways to classify rural areas. RUCAs use the Census Bureau's definitions of Urbanized Areas and Urban Clusters combined with population work commuting information to characterize the rural and urban status of census tracts. The RUCA classification is based on the size and population density of cities and towns, as well as their functional relationships as measured by work commuting flows.^[1]

In its *2005 National Profile of Local Health Departments*, NACCHO identified a total of 2,864 LHDs throughout the country. All LHDs were contacted and asked to complete a questionnaire. (The response rate for the questionnaire was 80 percent or 2,300 LHDs). In NORC's analysis of the resulting NACCHO data set, we used the Federal Office of Rural Health Policy convention defining rural as RUCA codes 4 and higher. RUCAs are coded on a scale of 1 to 10 and higher based on the definitions in the table below.

Exhibit 3. Rural-Urban Commuting Area (RUCA) Code Definitions

Code	RUCA Definition
1.	Urban core Census tract (Urbanized Area/Metro>50,000)
2.	Census tract strongly tied to urban core (primary flow to urban area >30%)
3.	Census tract weakly tied to urban core (primary flow to urban area ~5-30%)
4.	Large Town Census tract (primary flow within large Census Bureau defined Urban Place 10,000-49,999)
5.	Census tract strongly tied to large town (primary flow to Census Bureau defined Urban Place >30%)
6.	Census tract weakly tied to large town (primary flow to large Census Bureau defined Urban Place ~5-30%)
7.	Small Town Census tract (primary flow within small Census Bureau defined Urban Place (>10,000)
8.	Census tract strongly tied to small town (primary flow to a small Census Bureau defined Urban Place >30%)
9.	Census tract weakly tied to small town (primary flow to a small Census Bureau defined Urban Place ~5-30%)
10.	Isolated small rural Census tract (remaining tracts rural- no primary flows over 5% to defined Urbanized Area, large Urban Place, or small Urban Place)

^[1] Economic Research Service. Measuring Rurality: Rural- Urban Commuting Area Codes. United States Department of Agriculture Economic Research Group website. 2005. Available at <http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/>. Accessed February 7, 2007.