

Providing Assistance to Public Health Agencies Preparing for Accreditation

An RWJF national program

The Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) provided technical assistance and funding to help local, state, and tribal health departments prepare for accreditation. The National Indian Health Board developed a strategy for public health accreditation in Indian Country and provided technical assistance to promote and facilitate tribal participation.

The organizations worked together, and with the Public Health Accreditation Board, to align accreditation for local, state, and tribal health departments. They also collaborated to support the health departments participating in a beta test of public health accreditation and the quality improvement projects that followed. The National Association of Local Boards of Health was involved in some of this work.

CONTEXT

Public health departments play a critical, but often unrecognized, role in protecting and promoting the health of people in communities across the country. They are the front line of defense against many of our nation's most pressing health challenges—from chronic illness, to environmental threats such as food safety, to disaster preparedness and response.

To fulfill their mission, public health departments need to use their limited resources as wisely as possible. Accrediting public health departments will ensure that every community has access to the best health safeguards and to smart and efficient programs and services that can make a real difference in people's health.

Why Public Health Accreditation is Important

Public health accreditation seeks to advance quality and performance within local, state, tribal, and territorial health departments by establishing consistent standards and measuring their performance against those standards.

"Accreditation will ensure consistent, reliable access to basic services, help public health become more accountable to their communities, and create more effective programming and less waste," says Pamela Russo, MD, MPH, a senior program officer at the Robert Wood Johnson Foundation (RWJF) who has been involved in the Foundation's work in public health accreditation since it began.

Accreditation provides a way for health departments to identify opportunities for quality improvement (QI), strengthen management, develop leadership, and improve relationships with the community. It is also a process for documenting the capacity of health departments to carry out the three core functions of public health and to deliver the 10 public health services deemed essential by the Institute of Medicine. See Appendix 1 for more information about these.

"Accreditation is a top priority for the Foundation," said RWJF's Russo. "Health departments are a critical on-the-ground partner for much of what we do. Our efforts to reverse the upward trend in childhood obesity, to strengthen preparedness, to help the homeless, to reduce violence, to provide care for the poor and underserved, are put at risk if the health departments are weak, poorly supported, or ineffective."

RWJF's Interest in This Area

In 2004, RWJF convened public health stakeholders to determine whether they should further explore a voluntary national accreditation program for public health departments. The consensus was to proceed, and in 2005, RWJF and the Centers for Disease Control and Prevention (CDC) launched Exploring Accreditation of Public Health Departments.

Exploring Accreditation

Exploring Accreditation used an open, consensus-building framework in which public health practitioners and experts explored the feasibility and desirability of accrediting public health departments. The executive directors of four major public health organizations—American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and National Association of Local Boards of Health (NALBOH)—served on the planning committee.

The American Public Health Association, in Washington, is composed of public health professionals who work to improve public health in the United States; ASTHO, in

Arlington, Va., represents the leaders of state and territorial health departments; NACCHO, in Washington, represents local health departments; and NALBOH, in Bowling Green, Ohio, represents local health boards.

A steering committee and work groups comprised of representatives of local, state and federal public health departments and other practitioners developed a model accreditation program and vetted it through public health officials. ASTHO and NACCHO comanaged Exploring Accreditation.

Multi-State Learning Collaborative

RWJF's *Multi-State Learning Collaborative for Performance and Capacity Assessment on Accreditation of Public Health Departments* also informed this work. Launched in 2005, this program provided empirical evidence on public health accreditation or performance assessment in five participating states: Illinois, Michigan, Missouri, North Carolina and Washington.

It focused on enhancing the existing public health performance and capacity assessment or accreditation programs for local public health departments in four states, and local and state public health departments in one state. All states established state standards and a process to assess performance against the standards.

RWJF renamed the *Multi-State Learning Collaborative* in 2008. Its new name is *Lead States in Public Health Quality Improvement*.

Public Health Accreditation Moves Forward

In the winter of 2006, the Exploring Accreditation steering committee concluded that it was both desirable and feasible to establish a voluntary national accreditation program.

RWJF and the CDC supported the establishment of the Public Health Accreditation Board in May 2007 as the nonprofit entity to implement and oversee national public health department accreditation. This was part of RWJF's national initiative *National Accreditation of Public Health Agencies*.

RWJF launched other components of the initiative in the fall of 2007:

- Providing Assistance to Public Health Agencies Preparing for Accreditation, the
 subject of this report, supported strategic planning, pilot testing and quality
 improvement projects related to accreditation at local, state, and tribal health
 departments. It also studied the role of local boards of health and engaged in other
 accreditation-related work.
- Engaging Leaders in Advocacy for Public Health System Improvement Through Accreditation and Quality Improvement has supported activities that educate public health leaders, governing bodies, and policy-makers about accreditation,

involves them in designing program standards and measures when appropriate, and assures that they understand and support the benefits of accrediting health departments.

The program also:

- Works with federal government agencies, private foundations, and other potential funders to secure financial and programmatic incentives for public health accreditation.
- Supports modules on accreditation and QI that are included in RWJF's leadership training programs such as the *State Health Leadership Initiative*¹ and NACCHO's local public health leader orientation training.
- Building the Evidence Base for Public Health Accreditation and Quality
 Improvement, which funds research projects designed to measure the cost and
 impact of accreditation and the factors involved in its success. The last of these
 initiatives is scheduled to close in May 2012.

For a list of grants RWJF made under *National Accreditation of Public Health Agencies*, see Appendix 2.

THE PROGRAM

While the Public Health Accreditation Board was developing the public health accreditation process, RWJF began funding ASTHO and NACCHO to provide technical assistance and monetary support to help local, state, and tribal health departments prepare for accreditation. The Foundation also funded the National Indian Health Board² to develop a strategy for public health accreditation in Indian Country and to provide technical assistance to promote and facilitate tribal participation.

From September 2007 to August 2011, the participating organizations also worked to align accreditation for local, state, and tribal health departments. "The public health enterprise is interconnected at the federal, state, and local levels, and many states regularly interact with tribal public health leaders. For us to have concurrence on the standards and measures is important," said James A. Pearsol, MEd, ASTHO's chief of public health performance.

Management

RWJF program and financial staff managed *Providing Assistance to Public Health Agencies Preparing for Accreditation*.

¹ An RWJF program to accelerate the development of leadership capacity among state and territorial health officers as public health policy-makers, administrators and advocates.

² A nonprofit organization in Washington representing tribal governments

ACTIVITIES, RESULTS, AND EVALUATION FINDINGS

Accreditation Preparation and Quality Improvement Demonstration Sites Project

With initial funding from the CDC, NACCHO created the Accreditation Preparation and Quality Improvement Demonstration Sites Project in November 2007 to help 10 local health departments conduct self-assessments and start preparing for accreditation.

In 2008, RWJF expanded this project, funding NACCHO to work with 56 health departments, including the tribal health department of the Cherokee Nation (NACCHO worked with the National Indian Health Board to solicit applications from tribal health departments).³

Thirty-one of the local health departments conducted self-assessments, using NACCHO's Local Health Department Self-Assessment Tool for Accreditation Preparation, and implemented QI projects. Each health department received a \$15,000 grant from NACCHO (out of its funding from RWJF)

The remaining 25 local health departments worked together in five regional collaboratives. After conducting self-assessments, each collaborative aggregated its results within the region, chose priority areas to address through QI, and planned formal mechanisms for future collaboration. Each health department received a grant of up to \$20,000 from NACCHO (also out of its RWJF funding). The average grant was \$17,500.

NACCHO provided technical assistance, resource materials and other support to the sites. Technical assistance included a two-day Web-based training, webinars, conference calls, and one-on-one consultation with NACCHO staff.

Examples of Demonstration Site Projects

The site examples here highlight a diverse group of projects from various locales:

- Central Michigan District Health Department. This six-county district health department serves more than 191,000 people in the Michigan counties of Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon. During this project, staff developed a department-wide QI plan and processes to:
 - Accurately account for family planning supplies received in clinics and dispensed to clients.
 - Increase the use of prescribed HIV medications by HIV-positive individuals enrolled in the HIV Continuum of Care Program.
 - Annually review critical food violation rates and how they can be reduced.

³ Grant ID# 63686; February 2008 to May 2009

Read more about this work.

• Coconino County Health Department. This health department in North Central Arizona serves nearly 125,000 people. During this project, staff focused on engaging the community to identify and solve health problems in Williams, Ariz., and on evaluating the delivery of health services. The result was a community health profile with detailed census and vital statistics information and a list of local priorities.

Read more about this work.

• Region G Collaborative in Missouri. Missouri's Region G Collaborative consists of nine county health departments in South Central Missouri: Carter, Douglas, Howell, Oregon, Ozark, Reynolds, Shannon, Texas, and Wright. These health departments cover 7,462 square miles and serve 135,669 people. The collaborative did strategic planning to implement a community health improvement plan throughout the region based on assessments conducted by the county health departments.

Read more about this work.

Evaluation to Inform National Public Health Accreditation

NACCHO hired NORC (formerly the National Opinion Research Center) at the University of Chicago to evaluate its self-assessment tool and inform the Public Health Accreditation Board's development of national accreditation standards and measures:⁴

- Some 87 local health departments that participated in the demonstration projects completed a Web-based survey designed to assess the tool's ease of use and the clarity of the measures. The evaluators also conducted key informant interviews at 18 local health departments to learn more.
- Some 16 local health departments that are accredited through state-based accreditation programs completed a Web-based survey about the importance and relevance of the measures.

The evaluators received 1,200 comments through their surveys and interviews.

NACCHO also hired NORC to evaluate the technical assistance and resources it provided to the participating local health departments. For more information about this evaluation, see Appendix 3.

⁴ In addition to Grant ID# 63686, NACCHO used funds from RWJF Grant ID# 57248 (August 2006 to July 2008) to conduct this evaluation. See Program Results Report online: http://www.rwjf.org/pr/product.jsp?id=62228.

Evaluation Findings

NACCHO reported the following key findings from the NORC evaluation to the Public Health Accreditation Board and in an article in the *Journal of Public Health Management and Practice*:⁵

- Regardless of the size and capacity of the local health departments, most respondents saw the value in participating in the Accreditation Preparation and Quality Improvement Demonstration Sites Project.
- All of the local health departments felt that participating in the project would improve their overall effectiveness.
- There was near unanimous agreement among participating health departments that using the self-assessment tool was a useful first step in the accreditation process.
- Respondents said that almost all of the 45 standards included in the self-assessment tool were important.⁶

Sharing Demonstration Site Experiences With the Field

To share information from the demonstration sites with other local health departments, NACCHO created a section of its website with information about the project, and reports from each site or collaborative. The reports described the self-assessment process, results, lessons learned, and next steps. The collaboratives also documented the collaboration mechanism they established.

NACCHO added these materials or links to its Accreditation Preparation Toolkit and interactive map of states involved in accreditation and performance improvement activities. It also:

- Designated the projects of six health departments as model practices and nine as promising practices, and included these in its Web-based Model Practice Database.
- Held a webcast about the project.

NACCHO highlighted these resources on its website and wrote about them in the monthly *Dispatch* newsletter and newsletters on accreditation. Staff gave nine presentations related to this work.

⁵ Davis PB, Solomon J, Gorenflo G. "Driving Quality Improvement in Local Public Health Practice." *Journal of Public Health Management and Practice*. 16(1): 67–71, 2010. Available online.

⁶ The standards used in the project predated the existence of the Public Health Accreditation Board's standards; however, they were an input in the board's standards development.

Strategic Planning and Other Work on Public Health Accreditation in Indian Country

To engage tribes in the national public health accreditation process, RWJF funded the National Indian Health Board in 2008 to establish a strategic planning team and develop a strategic plan for advancing voluntary public health accreditation and public health standards in Indian Country. With a second grant beginning in 2010, the National Indian Health Board began work on implementing its strategic plan and related activities. 8

"There was a real question about whether the standards and measures being developed would apply to tribal public health," said RWJF's Russo. "We wanted to allow the tribes to do some exploratory work and see what they thought of public health accreditation."

Public Health in Indian Country

There are 565 federally-recognized tribes in the United States, each with a distinct language, culture, and governance structure. As sovereign nations, tribes are responsible for the overall health and well-being of their members. There is no single model for the structure of public health in Indian Country, or for the package of services available.

Traditionally, the Department of Health and Human Services' Indian Health Service has delivered health care to tribes, including some public health services. Since the 1970s, tribes have increasingly chosen to manage some or all of their own health programs through contracts and compacts with the Indian Health Service.

More than half of the tribes now have tribal health departments to manage their public health programs (see Appendix 4 for the Public Health Accreditation Board's definition of a tribal health department). Their activities may be supplemented by other public health programs funded by the tribe or other sources.

Diverse partners and stakeholders are often involved. Tribes can deliver public health services through federal, state, or other nonprofit grants and contracts. They may also partner with local and state health departments to provide public health services. Tribes with more resources or larger populations tend to be more involved in public health activities. Other variations reflect other tribal, regional, and state differences.

This diversity presents a challenge to the development of an accreditation process applicable to all tribal settings. "Very similar to how all of the states are very different both in culture and the way they operate, Indian Country is not the same across the nation," said Marjorie Paloma, MPH, one of the RWJF program officers who worked with the National Indian Health Board.

⁷ Grant ID# 63865; April 2008 to September 2009

⁸ Grant ID# 67544; April 2010 to September 2011

Nonetheless, public health accreditation is very important in Indian Country, according to Paul Allis, BSW, MEd, public health project manager at the National Indian Health Board. "It's all about raising public health to a new level in Indian Country. And it establishes accountability and credibility for folks working in the tribal health care system," he said.

The Strategic Planning Process

During its 2008 RWJF grant, the National Indian Health Board led a strategic planning process to explore accreditation and performance standards in Indian Country. The organization established a 22-member tribal public health accreditation advisory board to support that effort. Members included tribal representatives, governing board members of the National Indian Health Board, and representatives of key public health partner organizations. (For a complete list, see Appendix 5.) The National Indian Health Board also conducted interviews with tribal representatives and focus groups with tribal leaders and public health professionals.

Results: Developing and Implementing the Strategic Plan

According to the National Indian Health Board:

- It developed a comprehensive strategic plan to implement and engage tribes in public health accreditation. Overall, the strategic planning team determined that voluntary tribal public health accreditation was feasible, but noted these issues to consider:
 - Better education and articulation of the benefits of public health accreditation is needed for tribes to give meaningful input and consider this a priority.
 - The process and standards/measures/documentation must be adapted to the varied structures for public health service delivery in Indian Country.
 - While the tribes should be at the center of the accreditation process, partnerships and collaborations will be needed to fully deliver public health services and achieve accreditation. Key partners include the Indian Health Service, states, counties, local boards of health, and regional tribal organizations.
- The strategic plan outlined a series of short-term and long-term recommendations to achieve voluntary tribal public health accreditation.

Recommendations over the short-term (three to six months):

- Continue to provide education and increase awareness of voluntary public health accreditation among tribal leaders and public health professionals.
- Gather and review input from all tribes on the concept of voluntary tribal public health accreditation and the draft national standards.

- Consider whether to develop a tribal version of the draft national standards and measures.
- Secure resources for implementation.
- Develop criteria for selecting tribes to participate in the beta test.

Recommendations over the long term (six months to two years):

- Ensure that individuals with experience in Indian Country participate with tribes in the accreditation process, including reviewing the accreditation application and providing technical assistance.
- Develop relationships between the tribal public health accreditation advisory board and national public health entities involved in accreditation.
- Explore the national Public Health Accreditation's Board's role in strengthening relationships, coordination, and partnerships among state, local, and tribal health departments
- Evaluate implementation of the accreditation process at tribal settings.
- The National Indian Health Board worked with the tribes and the major public health partners to build strong relationships as staff developed the strategic plan and afterwards. "The most important part of this project was the cultivation and strengthening of the relationships across the tribes, within the tribes, and also with organizations outside of the tribes like RWJF, CDC, and the Public Health Accreditation Board," said RWJF's Paloma.

For example:

- In July 2009, the National Indian Health Board and the Public Health Accreditation Board signed a memorandum of understanding to work together to promote voluntary public health accreditation in Indian Country, to ensure that accreditation processes and standards are relevant to tribes, and to encourage tribal participation in accreditation efforts.
- The Public Health Accreditation Board includes a tribal representative and a representative of the National Indian Health Board.
- The Public Health Accreditation Board, ASTHO, and NACHCO have all participated in National Indian Health Board conferences.
- The National Indian Health Board worked with all of the accreditation partners and the tribes to promote the benefits of public health accreditation in Indian Country. For example:
 - Members of the tribal public health accreditation advisory board promoted public health accreditation to the public through presentations at national and regional conferences.

- The National Indian Health Board provided education about voluntary tribal public health accreditation within Indian Country through presentations, its national conferences, participation in CDC's tribal advisory committee, and practice briefs.⁹
- The National Indian Health Board provided technical assistance to help the Public Health Accreditation Board adapt its national accreditation approach to tribal public health delivery. The Public Health Accreditation Board's Tribal Standards Workgroup adapted the standards and measures, required documentation, and guidance to ensure its relevancy to tribal health departments.

Activities included:

- Developing a definition of eligibility for tribal health department accreditation and a set of tribal standards, measures, and interpretation guidance that is relevant, contextually appropriate, and culturally sensitive
- Making recommendations about where tribal health departments could collaborate with state and local health departments
- The National Indian Health Board also provided technical assistance and training on accreditation and public health QI to the tribes and to its national public health partners on how they can work with the tribes. (For more information about this, see the next section.

The Public Health Accreditation Beta Test and QI Projects

In July 2009, following a round of public comments and revisions, the Public Health Accreditation Board released a set of standards and measures for use in a beta test (a final test prior to release) of public health accreditation.¹⁰

Standards are the required level of achievement expected of a health department. They are grouped into 12 domains that include a broad group of public health services (e.g., "conduct and disseminate assessments focused on population health status and public health issues facing the community").

⁹ The practice briefs, started by the National Indian Health Board during this grant, focused on issues identified during the strategic planning process to help tribal public health departments prepare for accreditation and inform partner organizations about how tribal public health departments work. One brief, for example, described the Tribal Health Professions Opportunity Grants programs, designed to increase the health workforce in tribal communities.

¹⁰ The accreditation process was developed by the board's assessment process workgroup, which included state and local public health professionals, representatives from state-based accreditation programs, representatives from other national accreditation programs, and other technical experts. The standards and measures were developed by its standards development workgroup, which included state and local public health professionals, national and federal public health experts, public health researchers, and other technical experts. The most recent version of the Standards & Measures, approved May 2011, is available online. See Appendix 6 for a list of the domains and sample standards and measures for the first domain only. Use the online link to see those for other domains.

Measures provide a way of evaluating if the standard is met. There are 101 measures for local health departments and 110 measures¹¹ for state health departments, which are grouped into standards. Tribal health departments used the measures developed for local health departments.

The accreditation decision is based on the assessment of whether the health department has provided documentation demonstrating that it has conformed to these measures.

Choosing and Supporting the Beta Test Sites

The Public Health Accreditation Board chose 30 public health departments—19 local, eight state, and three tribal—for the beta test, from 148 applications. These health departments represented a diverse cross section of health departments nationwide. For a list of beta test sites, see Appendix 7.

RWJF funded ASTHO and NACCHO to provide technical assistance and financial support to the local, state, and tribal health departments for the QI projects aspect of the beta test. With funding from RWJF, the National Indian Health Board also provided this type of technical assistance to the participating tribes. The Public Health Accreditation Board provided technical assistance to the health departments on the beta test accreditation process.

NACCHO also worked with the National Network of Public Health Institutes, which was managing the RWJF program, *Lead States in Public Health Quality Improvement* (formerly called, the *Multi-State Learning Collaborative*), to encourage networking between the beta test sites and the lead states. The *Lead States* initiative was in its third and final phase by this time, with 17 states preparing their local and state health departments for national accreditation, contributing to development of the national accreditation program, and advancing the use of QI.

In order to emphasize the link between accreditation and quality improvement and the importance of quality improvement, following the beta test, RWJF funded each of the sites to design and implement a QI project in an area where the test showed a need for improvement, with additional help from ASTHO, NACCHO, and the National Indian Health Board.

¹¹ The number of measures used during the beta test is from an internal evaluation report.

¹² ASTHO: Grant ID# 66092; June 2009 to September 2011; ASTHO used this funding in part to administer grants of \$27,280 to each of the eight state and three tribal health departments. NACCHO: Grant ID# 66077; June 2009 to August 2011; NACCHO used this funding in part to administer grants of \$27,280 to the 19 local health departments.

¹³ This was part of the work done under Grant ID# 67544; April 2010 to September 2011.

Phases of the Beta Test

The Public Health Accreditation Board beta test took place in three major phases, running from fall 2009 to the end of 2012:

- **Application:** Participating health departments provided background information about their departments.
- **Self-assessment:** Participating health departments submitted relevant documentation to an online system to demonstrate that they had conformed to each measure.
- **Site visit:** After site visitors¹⁴ assigned to the health department reviewed the application and self-assessment, they visited the site to assess how well it had conformed to the measures. Each site visit team had three or four members. Site visits ranged from one and one-half to more than three days.

Beta Test Evaluation Findings

The National Opinion Research Center at the University of Chicago evaluated the beta test (all but the QI portion) for the Public Health Accreditation Board. Evaluators collected quantitative and qualitative data through web surveys, telephone interviews, the beta test applications, evaluation forms from training sessions, site visits, tracking tools, and other feedback from beta test sites, site visitors, and staff of the public health organizations involved in the accreditation project.

The evaluators reported the following findings from the beta test, which informed the final development of the public health accreditation program, launched in September 2011.

• Overall, beta test sites and site visitors gave very positive reviews of the accreditation processes and materials. Despite the time and money required, the sites were positive about their participation. In response to a survey several months after the last site visit, 28 of the 30 participants "strongly agreed" with the statement, "Our health department made the right decision to apply to be a beta test site." The two others "agreed" with the statement.

Staff at beta test sites also reported:

 The process had many benefits, including increased teamwork and improved staff morale and encouraging a culture of QI within the health department.

¹⁴ Primarily deputy directors or directors of health departments and people with environmental public health experience, along with some people with tribal, laboratory experience, or overall public health program experience.

- The process encouraged collaboration with members of the health department with whom they had rarely worked before and with entities outside the health department.
- The beta test prompted many health departments to appreciate the need to better document their policies and partnerships.
- Increased documentation was valuable for building institutional memory and communicating with partners and policy-makers. The process allowed health departments to appreciate the work they do and to gain more clarity on the direction they can take to improve.
- The majority of beta test participants indicated that only minor changes in the piloted approach were needed prior to the national launch of public health accreditation.

Other Feedback and a Revised Accreditation Approach

Throughout the beta test, NACCHO, ASTHO, and the National Indian Health Board provided the Public Health Accreditation Board with feedback from the participating health departments.

"We heard from a number of sites that it was very helpful to go through the beta test, to do a self-study to recognize their strengths and areas for improvement, and then have a site visit of national peers. They had a preview of what the accreditation board might be looking for in the future," said Jessica Solomon Fisher, MCP, director of accreditation preparation & QI at NACCHO.

"Each of the state sites made very visible progress in preparing for accreditation," added ASTHO's Lindsey Caldwell, MPH, senior director of performance improvement.

A key result for the National Indian Health Board has been the emphasis placed on collaboration and consultation between tribes and state health departments. "The accreditation process is stressing the importance of the consultation process with tribes. It's also encouraging tribes to come forward and talk to their state and local health departments so there can be that consultation," said Allis, the board's public health manager.

Based on the evaluation findings and the informal feedback, the Public Health Accreditation Board revised the public health accreditation process and standards. The *Evaluation of the PHAB Beta Test: Brief Report*¹⁵ describes these revisions, which were intended to provide greater clarity, reduce redundancy, and simplify requirements.

¹⁵ Pages 16–22

Examples of revisions included adding statements that describe the purpose and significance of each measure; providing greater specificity about the documentation health departments are required to provide; reworking the scoring system to use a fourpoint, rather than a three-point scale; and streamlining, clarifying or expanding some of the standards and measures within the domains.

"As a result of the beta test, the standards and measures were reformatted to make them very much better than they were at the beta test," said ASTHO's Pearsol.

The QI Projects Aspect of the Beta Test

Using the results of the Public Health Accreditation Board self-assessment, each participating health department designed and implemented a QI project. "Public health accreditation is meant to be a process of continuous quality improvement," said RWJF's Russo. "Even when a health department is accredited, accreditation site visitors will cite areas needing improvement, and health departments will need to explain in their annual reports their strategies for making those improvements."

The participating local, state and tribal health departments had an average of about seven months to implement their QI projects after the beta test site visit and report on them to ASTHO, NACCHO, and the National Indian Health Board, and at a final meeting for all beta test sites. 16 They appropriately chose narrowly focused QI projects that could feasibly be completed in six to seven months, such as:

- Improving immunization data entry timeliness in clinics (local health department)
- Increasing the number of homeless residents using the homeless health clinic (local health department)
- Decreasing the percentage of clients in the family planning clinics with wait times of more than two hours by improving the scheduling process
- Developing a well-defined process for communicating public health alerts (tribal health department)
- Providing faster and more accurate birth data to local health departments (state health department)
- Improving the website to communicate better with the public and provide clear contact information (state health department)

The health departments used the traditional management tool of a plan-do-study-act cycle, which is repeated again and again for continuous improvements:

Plan. Plan the test or observation, including a plan for collecting data.

¹⁶ The organizations also shared the reports with RWJF.

- Do. Try out the test on a small scale.
- *Study*. Set aside time to analyze the data and study the results.
- Act. Refine the change, based on what was learned from the test.

Staff also got hands-on experience using a range of other QI tools.

Results: QI Projects at Participating Health Departments

According to grantee reports and descriptions on the ASTHO and NACCHO websites:

 Participating sites reported measurable improvements in areas such as access to care, screening, reporting, health improvement planning, customer satisfaction, community engagement, clinic wait times, and revising and updating internal policies.

"Many individuals on the health department teams had no prior training or experience in quality improvement techniques," says Russo, "yet they were able to achieve results that exceeded expectations, even in a very short time frame."

Examples from local, state and tribal health departments are:

— Comanche County Health Department. Completing a community health improvement process with broad input from the community is one of the requirements for accreditation. The Comanche County Health Department in southwest Oklahoma serves a mixed urban and rural population, including three tribes and the residents of a major military post.

The team focused its QI project on improving the participation by representatives of 10 key sectors (e.g., health, school/education, youth, and business) in the community health assessment process. After analyzing the Comanche County Health Department's process for conducting meetings, team members recognized a need to focus on planning meetings properly. Their actions included preparing clear and concise meeting agendas, requesting RSVPs for meeting participation, and offering feedback in response to comments raised at meetings.

Based on follow-up surveys, the team reported a 30 percent increase in community participation at meetings, and ratings of meeting effectiveness that increased from 3.4 to 4.6 (on a scale of 1 to 5).

— City of Portland Public Health Division, Maine. The only comprehensive public health department in the state serves an urban, suburban, and rural population. The QI team focused on decreasing no-show rates at an HIV clinic by enhancing the process for updating patient information forms.

The QI team discovered a strong link between receiving a reminder phone call and showing up for an appointment. But clinic staff did not call many patients because they lacked correct contact information. The team implemented a new check-in process, with specific steps in place to ensure that updated contact information gets to the front desk and is entered into the computer system.

This resulted in a 45 percent decrease in no-show rates over two months after implementing the improvement.

— Wyoming Department of Health. Every state uses a simple blood test to do a metabolic screening that checks newborns for inherited diseases. The Wyoming Department of Health found that about 17 percent of newborn metabolic screening cards were missing information, including the doctor's name. This could delay treatment for a baby with an inherited disease, or even result in death.

The quality improvement team found many reasons for the missing data, including human error, laboratories that were unable to enter all of the data, and incomplete or inaccurate demographic information. Team members decided to educate staff at two Wyoming hospitals with the highest percentage of missing information on the importance of completely filling out the newborn metabolic screening card.

After the team developed an online training tool and held a series of meetings with hospital staff (including QI managers, laboratory supervisors, and coordinators of women and children's health), both hospitals quickly reduced the percentage of missing information, one by 17.4 percent (from 26.7% to 22.5%) and the other by 66.6 percent (from 35.8% to 12%).

— Keweenaw Bay Indian Community Department of Health and Human Services, Michigan. This tribal health department serves more than 3,200 people, primarily members of the Keweenaw Bay Indian Community Lake Superior Band of Chippewa Indians, a federally recognized tribe in Baraga, Mich.

A survey of clinic patients revealed that they were not happy with access to care and the amount of time they spent in the waiting room. To address this problem and increase patient satisfaction, the QI team implemented a less complicated scheduling process with fewer steps and hand-offs, informed medical staff and patients about it, and dealt with a backlog of appointments.

As a result, according to a patient survey, scheduled same-day appointments increased, the percentage of no calls/no shows decreased, and 96 percent of patients reported satisfaction with their services, exceeding the project goal of 75 percent.

• Health departments increased their focus on QI after participating in the beta test and QI projects:

 Many local health departments initiated more QI efforts, such as providing basic QI training to all staff, developing a plan and policies for QI, and forming a QI council.

- State health departments reported an increased focus on QI and some felt they
 were more prepared for accreditation.
- Tribal health departments reported an increased understanding of QI and how it can make all of their programming more effective and facilitate compliance with the requirements of funders.

Results: How the Beta Test and QI Projects Informed the Accreditation Process

According to interviews and reports to RWJF from project directors:

- The QI projects informed the development of the public health accreditation program. "They made it very clear that accreditation is all about QI," said RWJF's Russo. "It was a turning point in people's understanding that accreditation and QI were intertwined."
- The Public Health Accreditation Board used the results of the QI projects to
 inform its process for reporting results of the accreditation process to health
 departments. The board decided that every health department, including those that
 met accreditation standards, would get a report highlighting opportunities for
 improvement.
- The QI projects helped to inform the accreditation standards related to the performance measurement standard (Domain 9): "Evaluate and continuously improve health department processes, programs, and interventions."
- The beta test and QI projects increased the national focus on public health accreditation and will help other public health departments prepare for the process. The participating health departments contributed to the general knowledge about what it takes for health departments of varying sizes and structures to meet the accreditation requirements and how health departments should modify their daily work to prepare for accreditation.

"It's been a great opportunity for us to communicate the things that were learned from the beta test sites to other tribal public health departments who may be considering accreditation," said Allis of the National Indian Health Bureau.

ASTHO and NACCHO Evaluations

ASTHO and NACCHO each conducted their own evaluations of the support and technical assistance they provided during the QI projects. For more information, see Appendix 8.

The Role of Boards of Health in Public Health Accreditation

NALBOH studied the role that local advisory or governing boards of health play in the national accreditation program, through a subcontract from ASTHO.¹⁷

Under the subcontract, NALBOH:

- Conducted a focus group of representatives of local boards of health to collect feedback on the accreditation standards and measures for the Public Health Accreditation Board
- Established a workgroup of board of health members and experts on governance

Results of Work With Boards of Health

- NALBOH developed curriculum, webinars, and other resources about public health, accreditation, and QI and publicized these resources to its members through its newsletter and presentations. For example:
 - A Public Health 101 curriculum, featured on the association's website, enables
 members of local boards of health and other governing entities to become familiar
 with accomplishments in public health, the importance of QI, and the availability
 of technical assistance resources.
 - A QI webpage introduces boards of health to QI and includes examples of the QI process and specific scenarios illustrating how boards of health can be involved.
 - Other information about accreditation is available on the association's public health accreditation webpage. Click on the Accreditation Tools link.
- NALBOH surveyed the local boards of health that advised or governed the beta test sites to collect basic information about these boards and their approach to engaging in accreditation and QI activities. NALBOH sent the survey by email to 24 beta test sites (19 local and 5 state); 21 sites responded.¹⁸
 - Two-thirds of respondents identified their statutory role as governing.
 - A majority of boards of health (at least 52.9%) provided a letter of support to their health departments to engage in beta test activities and participated in the site visits, among other activities.

¹⁷ Advisory boards of health provide guidance on public health, policy, and programs within the public health department. Governing boards of health may be responsible for establishing local health ordinances, setting fees for services, approving health department budgets and more. Policy-making boards of health usually have legal authority to guide local public health departments. Board members can be either elected or appointed.

¹⁸ NALBOH excluded six sites: three states where the governing entity is the governor and three tribal sites, where there are conflicting reports as to which entity has the public health governing authority.

- A strong majority of boards of health meet and share information with their health departments at least monthly and have orientation and on-going education sessions for members.
- At least 50 percent of the respondents engaged in the following activities within the past three years:
 - Received beta test updates at meetings
 - Participated in the beta test site visit
 - Undertook strategic planning for the health department
 - Reviewed health department policies and procedures
 - Reviewed the health department budget

Communication Results

ASTHO, NACCHO, NALBOH, and the National Indian Health Board all provide information on their websites to help public health departments prepare for accreditation. This includes information about why accreditation matters, reports and case examples from the beta sites, toolkits, training materials and other resources. Most of these sites also include pages devoted to quality improvement.

- ASTHO has an accreditation webpage and a QI webpage:
- NACCHO has an accreditation preparation & QI webpage.
- NALBOH has a public health accreditation webpage and a QI webpage.
- The National Indian Health Board has a tribal public health accreditation project webpage.

For more information, see the Bibliographies.

LESSONS LEARNED

Lessons About Technical Assistance and Training

- 1. **Provide robust technical assistance to health departments working on QI.** QI in public health is new. NACCHO provided local health departments with comprehensive technical assistance, and staff reinforced the departments' successes, which helped them complete their QI projects. (Report by NACCHO to RWJF)
- 2. Help health departments working on QI select discrete projects that can be achieved in a short timeframe. The local health departments participating in the Accreditation Preparation and Quality Improvement Demonstration Sites Project and in the QI project aspect of the beta test had difficulty choosing QI projects that were

narrow enough in scope to be achieved within the project time frame. Providing more resources and technical assistance about this would have been helpful. (Report by NACCHO to RWJF)

3. **Include opportunities to apply QI theory to practice in technical assistance and training.** In the Accreditation Preparation and Quality Improvement Demonstration Sites Project, sites understood the theory in the training but had difficulty applying it to their projects.

After the beta test, NACCHO gave local health departments opportunities to apply what they were learning—for example, through exercises using QI tools or developing aim statements. "Providing opportunities for practical application during QI trainings had the most notable impact on knowledge and confidence of the sites implementing quality improvement," said a report by NACCHO to RWJF.

4. **Provide in-person training.** Local health departments felt that face-to-face networking with their peers and being able to apply what they were learning was important. "They were able to put faces with names and reach out to each other because they had met. The practical application of being able to do things right now with experts in the room is more useful than only having things like webinars or being sent information," said NACCHO's Fisher.

Lessons About Structuring Projects

5. **Be flexible, but include enough structure to guide participants.** NACCHO designed its Accreditation Preparation and Quality Improvement Demonstration Sites Project to give the local health departments maximum flexibility in how they designed their projects, worked with consultants, and allocated their staff time and funding. During the project, however, staff found that it was easier for the sites when NACCHO was more specific about deliverables and expectations.

In response, NACCHO staff created templates and guidance for all deliverables and formal memo notifications when deliverables were complete, and consistently reiterated the grant expectations. "Having a structure where there were intermittent deadlines and deliverables rather than, 'you have six months and this is due at the end,' seems to be very helpful to the sites," said NACCHO's Fisher.

- 6. Clearly outline expectations and offer support and technical assistance to help sites meet those expectations. During the QI projects, ASTHO staff checked in with individual state health departments by telephone, webcast, and email to remind them about every step of the work. Also, the reporting templates helped frame the technical assistance that ASTHO provided and ensured that the sites were on track. (Report from ASTHO to RWJF)
- 7. **Be flexible in the timing and scope of QI projects.** Because QI projects were built around opportunities identified during the beta test, the health departments could not begin the projects until after the beta test site visit, which in many cases occurred later

than anticipated. As a result, the health departments had less time than expected for their QI projects.

Also, some state health departments wanted to use their QI funding to continue their work on an existing QI effort. Had this been an option, the QI project might have had more immediate value to them. (Report from ASTHO to RWJF)

Lessons About Communication and Engagement

- 8. Ensure that communication methods will work with participants in a project. Given the large number of sites in the Accreditation Preparation and Quality Improvement Demonstration Sites Project, NACCHO staff originally communicated by email. After learning that emails were not the most effective way to communicate a large amount of information to the demonstration sites (in some cases sites could not get emails due to firewalls), NACCHO communicated through a website established specifically for the sites and through individual phone calls and weekly conference calls. (Report from NACCHO to RWJF)
- 9. Communicate the role of project participants clearly and concisely. NALBOH reported that boards of health are invested in ensuring that their public health departments are involved in the accreditation process, but that some are unclear about their specific roles and responsibilities. Developing the Public Health 101 Curriculum and conducting other learning activities helped the boards understand the basics of public health and accreditation-related/readiness topics. (Report from ASTHO to RWJF)
- 10. **Do not rely only on project participants to spread messages to their constituents or areas.** Originally, the National Indian Health Board relied on members of its strategic planning committee to promote public health accreditation within their own areas. They found, however, that some members had limited reach. To share information and engage public health leaders, staff made presentations at national and regional conferences, which proved to be more effective. (Report from National Indian Health Board to RWJF)
- 11. **Be clear about the scope and intention of the work when working with Indian tribes.** Tribes are somewhat reluctant to embark on relationships tied to government funding, due to historical mistrust. "We sometimes have to tread lightly and make sure it's a clean process and folks' politics are put on the table so everyone benefits," said the National Indian Health Board's Allis.

Other Lessons

12. **Look for opportunities to promote learning among colleagues.** Throughout this program, the national public health organizations worked together closely and found the opportunities to learn from each other very valuable.

For example, NACCHO and ASTHO shared tips on planning meetings and training and were able to share the work of developing the reporting templates. The National Indian Health Board provided Indian Health 101 to help the other organizations understand public health in Indian Country. Observing site visits and participating in site visitor training for the beta test helped NACCHO develop appropriate technical assistance for local health departments. (Report from NACCHO to RWJF)

- 13. To effectively engage tribal health departments, learn about the history and diversity of governmental public health structures in Indian Country. In working with tribal health departments, NACCHO found three strategies to be important: (1) demonstrating a genuine interest in the health and well-being of Native Americans; (2) building relationships; and (3) developing trust.
 - "It is critical to devote a significant amount of time to these ends before being able to effectively engage in meaningful work, even with the best intentions of enhancing public health in Indian Country," according to a NACCHO report to RWJF.
- 14. **Involving boards of health in their health department's QI activities strengthens both entities.** At some point, when the board of health understands the QI process, it may be beneficial for a representative to be a part of the health department's QI team. (Report from ASTHO to RWJF)

AFTERWARD

The Public Health Accreditation Board launched national voluntary accreditation for public health departments in September 2011 with continued funding from RWJF and CDC. ¹⁹ ASTHO, NACCHO, and the National Indian Health Board continue to support their members in preparing for accreditation and doing QI work. ASTHO and NACCHO also have funding from RWJF and CDC for this work.

RWJF has adopted the QI model used in *Providing Assistance to Public Health Agencies Preparing for Accreditation* in its public health grantmaking, requiring QI projects to be completed within a limited time period and including an initial meeting and coaching by a QI consultant.

ASTHO Work Funded by RWJF

In 2011, ASTHO began work on a project to demonstrate how applying QI in three core public health programmatic areas—maternal and child health, environmental health, and prevention and control of chronic diseases—can help states prepare for accreditation. ²⁰ Five states selected through a competitive process are participating: Arizona,

¹⁹ RWJF through Grant ID# PHAB; June 2007 to June 2013

²⁰ Grant ID# 69394; November 2011 to November 2013

Connecticut, Maryland, Minnesota, and Oregon. Each state will do QI projects in the three core areas.

ASTHO is working with the National Association of Chronic Disease Directors,²¹ the Association of Maternal and Child Health Programs,²² and QI consultants to:

- Provide on-site and distance-based technical assistance to the states.
- Provide opportunities for the states to develop peer learning and networking.
- Disseminate the results of the QI projects through national meetings, webinars, publications, and other means.

NACCHO Work Funded by RWJF

Community health assessment and community health improvement plans are two of the pre-requisites for accreditation. RWJF's project, helping local health departments improve the quality of community health assessments and community health improvement plans, ²³ is designed to:

- Help local health departments apply for national accreditation.
- Improve community health assessments and community health improvement plans.
- Model collaborations among academic institutions, nonprofit hospitals and public health institutes in conducting community health assessments and developing community health improvement plans.
- Work with the Public Health Accreditation Board on the standards and measures
 applicable to community health assessments and community health improvement
 plans.

The main part of this work involves NACCHO helping 12 local health departments complete community health assessments and community health improvement plans for accreditation preparation.

In the first project year of 2011, NACCHO convened a workgroup to select the participating health departments, and provided in-person and webinar trainings and individual telephone-based technical assistance. As of early 2012, all the sites are in

²¹ The National Association of Chronic Disease Directors, based in Atlanta, includes more than 3,000 specialized chronic disease practitioners working in public health departments across the country.

²² The Association of Maternal and Child Health Programs, in Washington, includes academic, advocacy and community-based family health professionals who work with state public health leaders to improve the health of women and children.

²³ Grant ID# 68474 to NACCHO; part of the program Community Health Assessment and Improvement Planning

progress on their community health assessments, and several have completed these assessments and moved forward into the community health improvement plan phase.

Under another RWJF grant,²⁴ NACCHO is providing technical assistance around accreditation preparation and QI to local health departments by:

- Developing an online tool to help local health departments collect and organize the documentation needed for accreditation
- Providing training and resources:
 - On developing strategic plans, a prerequisite for applying for accreditation
 - To help local health departments progress from doing no QI toward developing an organizational culture of QI
- Reviewing documentation for accreditation before a local health department submits it to PHAB
- Offering accreditation-preparation training at meetings of local health departments (e.g., meetings of state associations of county and city health officials)

NACCHO is also:

- Providing opportunities for local health departments to learn from and exchange experience with peers through webinars, regional meetings, teleconferences, and online learning communities
- Promoting the value of accreditation through a speakers bureau of "accreditation champions",²⁵ and a coordinated communications plan to promote the launch and monitor the progress of the national accreditation program.

CDC Funding to ASTHO and NACCHO

ASTHO and NACCHO also both have CDC funding to provide technical assistance to state and local health departments, respectively, on preparing for accreditation and QI, and related public health work. They are doing this work under cooperative agreements and as part of two CDC initiatives funded through the Affordable Care Act's Prevention and Public Health Fund:

• National Public Health Improvement Initiative supports state, tribal, local, and territorial health departments to make fundamental changes and enhancements in their organizations to improve the delivery and impact of public health services. CDC awarded grants to 76 local, state, tribal, and territorial health departments in 2010 and

²⁴ Grant ID# 69283; September 2011 to March 2013

²⁵ Accreditation champions are people from local health departments who participated in the beta test or are going through the accreditation process.

to 74 such health departments in 2011. CDC is also funding partner organizations such as ASTHO and NACCHO.

• Capacity Building Assistance to Strengthen Public Health Infrastructure and Performance funds ASTHO and NACCHO to provide capacity-building assistance for local, state, tribal, and territorial health departments to ensure successful adoption of practices that strengthen investments in core public health infrastructure.

This includes work to:

- Identify, synthesize, package, and disseminate best or promising practices and evaluate practices designed to increase the effectiveness and efficiency of public health infrastructure investments.
- Expand adoption and use of evidence-based approaches and The Guide to Community Preventive Services²⁶ among local, state, tribal, and territorial health departments and their partners. The guide is a free resource developed by the CDC to help communities choose programs and policies to improve health.

ASTHO also received funding for efforts to increase the available epidemiology workforce and expand existing e-learning technology.

CDC's Office for State, Tribal, Local and Territorial Support²⁷ is managing both of these programs. RWJF program officers regularly communicate with program officers there. "This ensures that we are working in complementary, synergistic ways to advance accreditation and QI," said RWJF's Russo.

Related RWJF Work

Through its program, *Strengthening the Community of Practice: Accreditation and Quality Improvement in Public Health*, launched in July 2011, RWJF is funding the National Network of Public Health Institutes²⁸ to increase momentum for public health accreditation and the use of QI by encouraging public health practitioners to share their experiences.²⁹

The National Network of Public Health Institutes is:

• Coordinating three national face-to-face meetings for public health practitioners

²⁶ The *Guide* is available online.

²⁷ This office works with state, territorial, and local health departments, and tribal governments, to achieve a healthier United States through the public health system.

²⁸ Based in New Orleans, the National Network of Public Health Institutes is the national membership network for public health institutes. These institutes are nonprofit organizations that improve the public's health by fostering innovation, leveraging resources, and building partnerships across sectors, including government agencies, communities, the health care delivery system, media, and academia.

²⁹ Grant ID# 69338; October 2011 to September 2013

- Managing a competitive QI minigrant program that combines funding and intensive, distance-based QI technical assistance
- Developing an online, searchable repository of public health QI projects, called the Practice Exchange, and coordinating public health partner organizations to promote use of the repository
- Managing a national advisory group for the Practice Exchange

National Indian Health Board

The National Indian Health Board is working to facilitate further collaboration with ASTHO, NACCHO, and NALBOH through formal agreements. Staff members are also working on the public health accreditation practice briefs.

Prepared by: Lori De Milto

Reviewed by: Karyn Feiden and Molly McKaughan

Program Officers: Pamela G. Russo and Marjorie A. Paloma

Grant ID # PHTA

Program area: Public health

APPENDIX 1

Three Core Functions and 10 Essential Services of Public Health

In its 1988 report, *The Future of Public Health*, the Institute of Medicine described three core functions of public health:

- 1. Assessment
- 2. Policy development
- 3. Assurance

Within this framework, there are 10 essential public health service activities that should be undertaken in all communities. These were developed in 1994 by a steering committee that included representatives from the U.S. Public Health Service agencies and other major public health organizations.

Assessment

- 1. Monitor health status to identify and solve community health problems.
- 2. Diagnose and investigate health problems and health hazards in the community.

Policy Development

- 3. Inform, educate, and empower people about health issues.
- 4. Mobilize community partnerships and action to identify and solve health problems.
- 5. Develop policies and plans that support individual and community health efforts.

Assurance

- 6. Enforce laws and regulations that protect health and ensure safety.
- 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- 8. Assure a competent public and personal health care workforce.
- 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- 10. Research for new insights and innovative solutions to health problems.

APPENDIX 2

National Accreditation of Public Health Agencies Grants

Providing Assistance to Public Health Agencies Preparing for Accreditation (PHTA)

Association of State and Territorial Health Officials (Arlington, Va.)

Assisting state health departments selected for beta testing of the national Public Health Accreditation Board program

Grant ID# 66092 (June 2009 to June 2011)

Project Director

James Pearsol, MEd (202) 371-9090 jpearsol@astho.org

National Association of County and City Health Officials (Washington, D.C.)

Accreditation preparation and quality improvement

Grant ID# 63686 (February 2008 to May 2009)

Assisting local health departments selected for beta testing of the national Public Health Accreditation Board program

Grant ID# 66077 (June 2009 to August 2011)

Project Director

Jessica Solomon Fisher, MCP (202) 507-4265 jfisher@naccho.org

National Indian Health Board (Washington, D.C.)

Exploring tribal public health accreditation project

Grant ID# 63865 (April 2008 to September 2009)

Providing technical assistance to promote and facilitate tribal participation in national public health accreditation

Grant ID# 67544 (April 2010 to September 2011)

Project Director

Paul Allis, BSW, MEd (202) 507-4085 pallis@nihb.org

Other Grants and Authorizations Related to National Accreditation of Public Health Agencies

Public Health Accreditation Board

Cole Communications (Aptos, Calif.)

Conducting an evaluability assessment of RWJF's Survive and Thrive program Grant ID# 66065 (May 2009 to October 2010)

National Association of County and City Health Officials (Washington, D.C.)

Establishing a national public health accrediting organization (Phase 1)

Grant ID# 61340 (June 2007 to August 2008)

Training newly appointed public health officials in applying knowledge and specific skills to their leadership roles

Grant ID# 63781 (June 2008 to November 2009)

Grant ID# 67036 (January 2010 to December 2011)

Public Health Accreditation Board (Alexandria, Va.)

Establishing a national public health accrediting organization

Authorization ID# PHAB (June 2007 to June 2013)

Providing a reserve fund for the Public Health Accreditation Board to support operations Grant ID# 69361 (November 2011 to October 2015). Part of *Engaging Leaders in Advocacy for Public Health System Improvement Through Accreditation and Quality Improvement*

RWJF's Program: Building the Evidence Base for Public Health Accreditation and Quality Improvement

Baltimore City Health Department (Baltimore, Md.)

Enhancing and evaluating quality improvement in the Baltimore City Health Department Grant ID# 66188 (June 2009 to June 2011)

Berrien County Health Department (Berrien County, Mich.)

Improving efficiency of the Berrien County (Mich.) Health Department services using quality improvement and quality assurance

Grant ID# 66242 (June 2009 to June 2011)

City of Milwaukee Health Department (Milwaukee, Wis.)

Increasing adolescent immunization rates through school-based clinics Grant ID# 66199 (June 2009 to June 2011)

Community Health Foundation (Tulsa, Okla.)

Implementing and evaluating the comprehensive quality improvement program at the Tulsa Health Department (Oklahoma)

Grant ID# 66239 (June 2009 to June 2011)

County of Los Angeles Department of Public Health (Los Angeles, Calif.)

Instituting a collaborative approach to quality improvement in a large urban public health department

Grant ID# 66198 (August 2009 to June 2011)

Duval County Health Department (Jacksonville, Fla.)

Evaluating quality improvement approaches to improve immunizations in Jacksonville, Fla.

Grant ID# 66258 (June 2009 to June 2011)

Franklin County Board of Health (Franklin County, Ohio)

Using quality improvement processes to increase the number of immunizations in a target population in Franklin County, Ohio

Grant ID# 66192 (June 2009 to June 2011)

Guilford County Department of Public Health (Guilford County, N.C.)

Using the Six Sigma process in a public health clinic system in Guilford County, N.C., to improve health outcomes

Grant ID# 66185 (June 2009 to December 2011)

Ingham County (Ingham County, Mich.)

Evaluating whether a communities-of-practice approach can make quality improvement more effective in a public health setting

Grant ID# 66196 (June 2009 to June 2011)

Port Gamble S'Klallam Tribe (Kingston, Wash.)

Evaluating a new electronic medical records system as part of quality improvement at the Port Gamble S'Klallam Tribe health department

Grant ID# 66194 (June 2009 to July 2011)

State of South Carolina Department of Health & Environmental Control (Columbia, S.C.)

Conducting a quality improvement project in family planning clinics in two South Carolina public health departments

Grant ID# 66187 (June 2009 to June 2011)

Tacoma-Pierce County Health Department (Tacoma, Wash.)

Evaluating a comprehensive quality improvement initiative at a local health department Grant ID# 66197 (June 2009 to June 2011)

University of Minnesota School of Public Health (Minneapolis, Minn.)

Technical assistance and direction for RWJF's *Building the Evidence Base for Public Health Accreditation and Quality Improvement* program

Grant ID# 64349 (July 2008 to March 2012)

Yellowstone City-County Health Department (Billings, Mont.)

Implementing quality improvement in food-borne illness prevention, detection and intervention in a city-county health department in Montana

Grant ID# 66256 (June 2009 to June 2011)

APPENDIX 3

Evaluation of NACCHO Technical Assistance and Resources for Accreditation Preparation and Quality Improvement Demonstration Sites Project

Methodology

The National Opinion Research Center evaluated NACCHO's technical assistance and resources through:

- A Web-based survey of local demonstration sites (54 of 66, including sites funded by Centers for Disease Control and Prevention, participated)
- A separate Web-based survey of the "technical assistance extravaganza" (a two-day Web training) (34 of 56 local demonstration sites participated on day 1 and 28 of 56 participated on day 2)

Findings

In an article in the *Journal of Public Health Management and Practice*, ³⁰ the National Opinion Research Center reported:

- The top three most useful quality improvement resources were:
 - Public Health Memory Jogger II: A Pocket Guide of Tools for Continuous Improvement and Effective Planning
 - Tools provided by consultants

³⁰Berryman Davis P, Solomon J, Gorenflo G. "Driving Quality Improvement in Local Public Health Practice." *Journal of Public Health Management and Practice*. 16(1): 67–71, 2010. Available online.

- NACCHO's online Accreditation Preparation and Quality Improvement Toolkit
- The most useful means of support offered by NACCHO were:
 - Networking with other health departments during calls and webcasts
 - One-on-one consultation with NACCHO staff (phone calls, emails, and in-person meetings)

APPENDIX 4

Definition of a Tribal Health Department

For the purposes of accreditation, the Public Health Accreditation Board defines a tribal health department as:

"A federally recognized tribal government, tribal organization, or inter-tribal consortium, as defined in the Indian Self-Determination and Education Assistance Act, as amended. Such departments have jurisdictional authority to provide public health services, as evidenced by constitution, resolution, ordinance, executive order, or other legal means, intended to promote and protect the tribe's overall health, wellness and safety; prevent disease; and respond to issues and events. Federally recognized tribal governments may carry out the above public health functions in a cooperative manner through formal agreement, formal partnership, or formal collaboration."

APPENDIX 5

National Indian Health Board Tribal Public Health Accreditation Advisory Board

The board members listed below include:

- Tribal representatives from 10 of the 12 Indian Health Service areas, including tribal health directors and public health professionals
- Members of the governing board of the National Indian Health Board
- Representatives from RWJF, CDC, NACCHO, ASTHO, NALBOH, and the Public Health Accreditation Board

Tribal Representatives

Agatha Amos

Health Education Director Division of Health Programs Flagstaff, Ariz. Representing the Phoenix Area

Jessica Burger, RN

Health Director Little River Band of Ottawa Indians Manistee, Mich. Representing the Bemidji Area

Alfreda Doonkeen

Wewoka Service Unit, Oklahoma City Area Inter-Tribal Health Board Oklahoma City, Okla. Representing the Oklahoma Area

Joe Finkbonner, RPh, MHA

Executive Director Northwest Portland Area Indian Health Board Portland, Ore. Representing the Portland Area

Deborah Herrera

Southern Ute Tribe Health Service Division Head Ignacio, Colo. Representing the Albuquerque Area

Stephen Kevin Howlett

Department Head Confederated Salish & Kootenai Tribes Tribal Health & Human Services Pablo, Mont. Representing the Billings Area

Jackie Kaslow

Director
Family and Community Health Services
California Rural Indian Health Board
Sacramento, Calif.
Representing the California Area

Robert Moore

Councilman, Rosebud Sioux Tribe Rapid City, S.D. Representing the Aberdeen Area

Madan Poudel, PhD

Health Services Administrator Navajo Division of Health Window Rock, Ariz. Representing the Navajo Area

Ileen Sylvester, MBA

Vice President Executive and Tribal Services Southcentral Foundation Anchorage, Alaska Representing the Alaska Area

Representing the National Indian Health Board, Governing Board

Kaye Bender, PhD, RN, FAAN

President and CEO Public Health Accreditation Board Alexandria, Va.

Liza Corso, MPA

Team Lead, Performance Standards and Accreditation Office of Chief of Public Health Practice Centers for Disease Control and Prevention Atlanta, Ga.

Grace Gorenflo, MPH, RN

Project Director National Association of County and City Health Officials Washington, D.C.

James A. Pearsol, MEd

Chief Program Officer
Public Health Performance
Association of State and Territorial Health
Officials
Arlington, Va.

Yolanda Savage

Project Director Performance Standards and Accreditation National Association of Local Boards of Health Bowling Green, Ohio

Other Representatives

Stacy Bohlen

Executive Director National Indian Health Board Washington, D.C.

Aimee Centivany, MPH

Senior Advisor, Grants Management National Indian Health Board Washington, D.C.

Aleena Hernandez, MPH

Technical Consultant Red Star Innovations, LLC Tucson, Ariz.

Marjorie A. Paloma, MPH

Program Officer Robert Wood Johnson Foundation Princeton, N.J.

Yvette Roubideaux, MD MPH

Technical Consultant The University of Arizona Tucson, Ariz.

H. Sally Smith

Board Member National Indian Health Board Washington, D.C.

Jerry Spegman

Senior Program Consultant Robert Wood Johnson Foundation Princeton, N.J.

APPENDIX 6

PHAB's Twelve Domains and Sample Standards and Measures for One Domain

The full version of the Standards & Measures, approved May 2011, is available online.

Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.

Domain 1 includes four standards, such as "participate in or conduct a collaborative process resulting in a comprehensive community health assessment" and "collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population."

The first of the four standards within Domain 1 contains five measures, such as "participate in or conduct a state partnership that develops a comprehensive state community health assessment of the population of the state."

- Domain 2: Investigate health problems and environmental public health hazards to protect the community.
- Domain 3: Inform and educate about public health issues and functions.
- Domain 4: Engage with the community to identify and address health problems.
- Domain 5: Develop public health policies and plans.
- Domain 6: Enforce public health laws.
- Domain 7: Promote strategies to improve access to health care services.
- Domain 8: Maintain a competent public health workforce.
- Domain 9: Evaluate and continuously improve health department processes, programs and interventions.
- Domain 10: Contribute to and apply the evidence base of public health.
- Domain 11: Maintain administrative and management capacity.
- Domain 12: Maintain capacity to engage the public health governing entity.

APPENDIX 7

The Beta Test Sites

Local Health Departments

Austin/Travis County Health and Human Services Department, Texas

Cabarrus Health Alliance, N.C.

Carson City Health and Human Services Department, Nev.

Central Valley Health District, N.D.

City of Portland Public Health Division, Maine

Coconino County Health Department, Ariz.

Comanche County Health Department, Okla.

County of San Diego Health and Human Services Agency, Calif.

Deschutes County Health Services, Ore.

Franklin County Health Department, Ky.

Hennepin County Human Services and Public Health Department, Minn.

Mahoning County District Board of Health, Ohio

Miami-Dade County Health Department, Fla. Northampton Health Department, Mass. and the Quabbin Health District, Mass. (joint applicants)

Norton County Health Department, Kan. Public Health Solutions District Health Department, Neb.

Tioga County Health Department, N.Y.
Tooele County Health Department, Utah

Township of Bloomfield Department of Health and Human Services, N.J.

State Health Departments

Florida Department of Health, Tallahassee, Fla.

Iowa Department of Public Health, Des Moines, Iowa

Michigan Department of Community Health, Lansing, Mich.

Mississippi State Department of Health, Jackson, Miss.

Ohio Department of Health, Columbus, Ohio Oklahoma State Department of Health, Oklahoma City, Okla.

Washington State Department of Health, Olympia, Wash.

Wyoming Department of Health, Cheyenne, Wyo.

Tribal Health Departments

Keweenaw Bay Indian Community Department of Health and Human Services Baraga, Mich.

Navajo Nation Division of Health, Window Rock, Ariz.

Cherokee Nation Health Services, Tahlequah, Okla.

APPENDIX 8

ASTHO and NACCHO Evaluations of Their Support and Technical Assistance for the QI Projects

The ASTHO Evaluation

ASTHO conducted an online survey to assess satisfaction with its administration, support and technical assistance of the QI projects; seven of the eight participating states completed the survey.

Findings

- Participating states rated their overall satisfaction with ASTHO's support and technical assistance a 4 on a scale of 1 to 5 (1 being strongly dissatisfied and 5 being strongly satisfied).
- In-person meetings were the most useful form of technical assistance.
- Other types of technical assistance and support the states would have valued were:
 - More funding for the beta test portion of the project
 - Technical assistance targeted to preparing the Public Health Accreditation Board accreditation prerequisites
 - Tailored one-on-one technical assistance to customize work to the state's level of readiness
 - Examples of best-practice tools
 - Templates and resources from other states
 - Overall accreditation readiness assessments prior to the Public Health Accreditation Board self-assessment.

The NACCHO Evaluation

NACCHO conducted an online survey of local health departments to assess the effectiveness of its technical assistance around QI and its understanding of the technical assistance needs of local health departments. Sixteen of the 19 sites participating in the beta test completed the survey.

Findings

- Overall, the sites rated NACCHO's provision of technical assistance very favorably. All sites either "strongly agree" or "agree" that:
 - NACCHO responded to technical assistance requests in a timely manner.

- The process for contacting NACCHO was clear.
- NACCHO contacted the sites with appropriate frequency during the QI projects.
- Favorability dropped slightly when asked whether:
 - NACCHO was knowledgeable about QI (6% reported "neither agree or disagree").
 - Guidance provided by NACCHO was relevant to their QI effort (13% reported "neither agree or disagree").
- The most highly rated technical assistance and resources were in-person training and the mid-term and final report templates (all of the respondents who had used them either agreed, or strongly agreed, that they were useful). One-on-one calls, monthly enewsletters and a tool called the *Public Health Memory Jogger* earned those ratings from 94 percent of respondents.

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