Establishing a National Public Health Accreditation Organization
An RWJF National Program

EXECUTIVE SUMMARY

The Robert Wood Johnson Foundation (RWJF) and the Centers for Disease Control and Prevention (CDC) supported the establishment of an independent, nonprofit organization—the Public Health Accreditation Board (PHAB)—to develop and manage the first national voluntary accreditation program for public health departments. Under PHAB’s guidance, public health practitioners built the accreditation program, with assistance from major public health associations and other experts.

As of December 2014, nearly 205 million Americans—about 66 percent of the total population—are served by either an accredited health department or a health department that has applied for accreditation.

As of December 2014, RWJF has contributed $14.3 million. Since May 2007, CDC has contributed $7.7 million.1

CONTEXT

Public health departments play a critical, but often unrecognized, role in promoting and preserving the health of people in communities nationwide. But by 1988, the nation had “lost sight of its public health goals” and allowed the public health system to “fall into disarray,” according to the Institute of Medicine’s report, The Future of Public Health (1988). Public health practitioners, policymakers, and the public did not understand what people should expect from public health, and services varied widely from place to place.

Things had not improved by 2002, when the Institute of Medicine recommended establishing a national steering committee to explore accreditation of governmental

1 The $7.7 million from CDC represents funds only to PHAB from May 2007 through 2014. The CDC figure does not include CDC accreditation-related funds to other national partners or to health departments in the field for accreditation readiness.

**RWJF Funds Work to Improve Public Health**

RWJF staff saw public health accreditation as a way to build on RWJF’s earlier investments to improve the performance and impact of the public health system; increase the accountability of public health departments for quality services, processes, and community health outcomes; and increase support for public health.

Program staff also thought accreditation could catalyze public health departments to implement quality improvement. QI, as it is widely known in the field, is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. According to The National Association of County and City Health Officials’ (NACCHO) website, “It is a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.”
For information on:

- RWJF’s notable investments in improving the performance and impact of the public health system, see Appendix 1.
- RWJF’s work through April 2010 in and related to public health accreditation, see the Special Report: Exploring Accreditation of Public Health Departments.
- RWJF’s more recent work to support accreditation and QI, see Appendix 2.

**RWJF and CDC Partner to Explore Accreditation**

Acting as a neutral convener, in 2004 RWJF brought together public health stakeholders to discuss public health accreditation.² Participants represented state and local health departments, public health membership organizations, the Centers for Disease Control and Prevention (CDC), and other federal agencies. The consensus was to proceed with exploring accreditation of public health departments.

RWJF and CDC partnered in the Exploring Accreditation project,³ launched in 2005, to determine the feasibility and desirability of accrediting public health departments. CDC, in 2004, had identified accreditation as a key strategy for strengthening the public health infrastructure. Partnering with RWJF was crucial to CDC in bringing public health stakeholders together. “If it were just CDC, there would be suspicion about us trying to control the public health enterprise,” said Dennis Lenaway, PhD, MPH, who was director of CDC’s Office of Public Health Systems Performance at that time.⁴

Public health practitioners were very wary of accreditation, says Pamela G. Russo, MD, MPH, a senior program officer at RWJF. They were afraid that it could penalize health departments that were small or under-resourced, or suggest that high-performing health departments were overfunded. They also saw it as potentially another time-consuming burden and an unfunded mandate that would not help their health departments improve.

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² Grant ID 51173 ($50,000, July 1, 2004 to December 31, 2004); and ID 52159 ($85,000, November 1, 2004 to February 28, 2006)
³ Grant ID 53182 ($742,377, June 15, 2005 to Mary 31, 2007); ID 56262 ($35,743, December 1, 2005 to February 28, 2006); and ID 58881 ($749,528, December 1, 2006 to December 31, 2008)
⁴ He is now acting chief of the Public Health Practice and Policy Branch.
“As a neutral convener, we could ensure that the public health practitioners drove the process, discussed and addressed their fears, and set up guiding principles to prevent negative outcomes,” said RWJF’s Russo.

**Public Health Practitioners Develop a Consensus**

The Exploring Accreditation project used an open, consensus-building framework driven by public health practitioners and experts to explore accreditation. The executive directors of the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) comprised the planning committee. Other public health practitioners and experts, including representatives of local, state, and federal public health departments, were part of a 25-member steering committee.

Four workgroups—standards/measures, accreditation process, finance, and evaluation/research—comprised of representatives of health departments and other organizations informed the work of the steering committee. Representatives from the field included those that were participants in RWJF’s program, *Multistate Learning Collaborative on Performance and Capacity Assessment on Accreditation of Public Health Departments*.

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**Public Health Organizations**

American Public Health Association (APHA), in Washington, is composed of public health professionals and works to improve public health in the United States.

Association of State and Territorial Health Officials (ASTHO), in Arlington, Va., is the nonprofit public health organization that represents the leaders of state and territorial health departments.

National Association of County and City Health Officials (NACCHO), in Washington, is the national organization representing local health departments.

National Association of Local Boards of Health (NALBOH), in Kimberly, Wis., represents local health boards.

National Network of Public Health Institutes (NNPHI) in Washington and New Orleans, fosters networking and collaboration among public health institutes and multisector partners.
(Multistate Learning Collaborative),5 The National Network of Public Health Institutes (NNPHI) managed this program.

**Multistate Learning Collaborative (MLC)**

RWJF’s Multistate Learning Collaborative initially funded five states with experience in public health accreditation or performance assessment to enhance their processes and inform the work of the steering committee and other states. The states—Illinois, Michigan, Missouri, North Carolina, and Washington—provided empirical evidence about what worked and what did not.

“*The goal was to have them exchange with each other their best practices and also inform the Exploring Accreditation steering committee about real-world practice in public health, instead of theory.*”—RWJF’s Pamela Russo

RWJF funded two more phases of the Multistate Learning Collaborative: MLC-2 with 10 states from 2006–2008 and MLC-3 with 16 states from 2008–2011, as described below. In 2008, the program was officially renamed Lead States in Public Health Quality Improvement, although informally, it was still referred to as MLC. The participating states continued to inform the development of public health accreditation.

Read the Program Results Report on the Multistate Learning Collaborative/Lead States in Public Health Quality Improvement.

**Public Health Accreditation Moves Forward**

In 2006, the Exploring Accreditation steering committee unanimously recommended establishing a national voluntary public health accreditation program for Tribal, state, local, and territorial health departments and made recommendations on the structure of the program.

More than 650 public health practitioners commented on the model outlined in the steering committee’s final report, *Exploring Accreditation: Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments*. The report also called for establishing an independent, nonprofit organization to manage the accreditation program.

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5 Grant ID MLC ($15,216,961.54, August 1, 2005 to December 15, 2011)
For more information about early work towards public health accreditation, read the RWJF *Special Report: Exploring Accreditation of Public Health Departments*.

**THE PROGRAM: LAUNCHING PUBLIC HEALTH ACCREDITATION**

Since 2007, RWJF and CDC have supported the establishment and operations of the Public Health Accreditation Board (PHAB) to develop and manage the national voluntary public health accreditation program.6

Under the guidance of the Public Health Accreditation Board, the public health accreditation program was “built by practitioners for practitioners,” says RWJF’s Russo. Experts in accreditation provided guidance, but “it was the local, state, and Tribal health departments who were making the decisions. That was key.” Some 400 public health practitioners contributed to the development of the program.

> “CDC and RWJF felt very strongly that the accreditation program had to be peer-driven, practice-based, and voluntary.”—Liza Corso, MPA, CDC’s Office for State, Tribal, Local and Territorial Support

Major public health associations also played a key role in developing the public health accreditation program: American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County & City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH), and the National Indian Health Board (NIHB).7

The Public Health Accreditation Board was designated a tax-exempt nonprofit organization in 2008 and appointed Kaye Bender, RN, PhD, FAAN, president and CEO in 2009. Bender had served as chair of the Exploring Accreditation steering committee. At the time, she was dean of the University of Mississippi Medical Center’s School of Nursing. Prior to that, she had spent more than 26 years in local and state public health in Mississippi.

6 Grants to NACCHO to support public health accreditation are: Grant ID 61340 ($985,035, June 1, 2007 to August 31, 2008); Grant ID 65090 ($853,140, September 1, 2008 to March 31, 2009); and Grant ID 65570 ($979,930, February 15, 2009 to December 31, 2009).

Grants to PHAB are: Grant ID 66647 ($842,769, September 15, 2009 to June 30, 2010); Grant ID 67766 ($1,631,189, July 1, 2010 to May 31, 2011); Grant ID 68923 ($1,449,073, June 1, 2011 to May 31, 2012); Grant ID 69985 ($1,463,077, June 1, 2012 to June 30, 2013); Grant ID 70974 ($1,648,837, July 1, 2013 to June 30, 2014); and Grant ID 71860 ($1,502,147, July 1, 2014 to June 30, 2015).

7 NIHB is a nonprofit organization in Washington representing Tribal governments.
Bringing Complementary Expertise to the Table

RWJF’s expertise in launching nonprofit organizations and CDC’s expertise in developing standards were both key in the development of the board and public health accreditation. Financial and legal professionals at RWJF helped PHAB leaders and board members put the organization on a solid business footing and develop the board. They monitored the board’s progress and provided feedback.

CDC’s Office for State, Tribal, Local and Territorial Support shared its expertise in developing standards and metrics. This included ensuring that the public health accreditation standards and measures are well aligned with other national efforts to assess and strengthen public health. In particular, the standards development process drew lessons and content from CDC National Public Health Performance Standards program.

CDC’s Office for State, Tribal, Local and Territorial Support also drew in subject matter experts from elsewhere in CDC to inform content of the standards, as needed. For example, the accreditation standards and measures and glossary terms that address preparedness are consistent with content in CDC Office of Emergency Preparedness and Response capabilities.

Developing the Accreditation Program

PHAB formed the Standards Development Workgroup to craft accreditation standards, including measures to assess health departments’ performance, and the assessment process workgroup to develop the accreditation process. Participants included:

- State and local public health professionals, including those from health departments that would be eligible for accreditation
- Representatives of state-based public health accreditation and national accreditation programs outside public health
- Public health and technical experts and public health researchers from academia, business, and the public sector

The standards were designed to work for all health departments, regardless of size, governance, organizational structure, and community health needs. The standards development workgroup built on state-based public health accreditation programs, the National Public Health Performance Standards, and NACCHO’s Operational Definition of a Functional Local Health Department.

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8 Developed by APHA, ASTHO, CDC, NACCHO, NNPHI, and the Public Health Foundation, these standards provide a framework to assess capacity and performance of public health systems and public health governing bodies.
9 Developed with funding from RWJF; see Appendix 1 for more information.
“We wanted to create stretch standards, so even the best of the best would have to work toward something. We also wanted to make accreditation achievable.”—Mary Kushion, MSA, then the health officer at the Central Michigan District Health Department

**MLC Phase 2 and Phase 3**

As the accreditation program was being developed, grantees in the 17 states participating in the second and third phases of the *Multistate Learning Collaborative/Lead States in Public Health Quality Improvement* continued to inform the process.

“MLC built a community of exchange and mutual support. It had a huge impact on changing attitudes toward and building momentum for accreditation.”—RWJF’s Pamela Russo

MLC-2, launched in 2006, explored best practices for teaching and implementing QI in public health and continued to enhance accreditation readiness. It was designed to integrate QI into existing performance and capacity assessment or accreditation efforts.

MLC-3, from 2008–2011, prepared health departments for accreditation and advanced their use of QI. Each state formed a minicollaborative to test QI tools and techniques in target areas where change could be documented and measured, such as customer service or reducing the infant mortality rate.

“We saw this as a significant opportunity to move our public health agency forward in terms of QI. Accreditation was a great way to answer the question: How do we know the health department’s doing what it should be doing?”—Terry L. Cline, PhD, Oklahoma Commissioner of Health

Oklahoma later became one of the first two states to be accredited, along with Washington state, which participated in all three phases of MLC.

Read the **Program Results Report** on the *Multistate Learning Collaborative*.

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10 After retiring in 2013, she became an accreditation consultant.
Building Support

While some health departments understood the value of accreditation early on, many others were either unaware of the movement toward public health accreditation or fearful about its potential impact on their health departments.

Health departments vary widely in capacity, resources, community and political support, and authority. Going through the accreditation process would be costly and labor intensive and could potentially damage the reputations of health departments. Small health departments were especially worried that accreditation might be tied to funding, and that they might not be able to meet the standards.

An online survey PHAB commissioned from Porter Novelli in 2008 showed that 57 percent of the responding health departments were unsure or undecided about whether to seek accreditation.

The Accreditation Coalition

Shortly after the PHAB’s inception, RWJF and CDC began funding the Accreditation Coalition to help PHAB address resistance to accreditation. Comprised primarily of the national public health organizations that partnered with PHAB (including APHA, ASTHO, NACCHO, NALBOH, and NIHB), the coalition met periodically to ensure consistent, strategic promotion of accreditation. Other coalition members were the Association of Public Health Laboratories (APHL), National Network of Public Health Institutes (NNPHI), and Public Health Foundation.

Communication With the Field

PHAB staff realized early on that communication with the field would be vital to health departments’ acceptance of accreditation. In 2008, PHAB hired its first communications director. Partnering with national public health organizations to ensure coordinated and timely messages to their members was a key part of the communications strategy.

Another key strategy was sending PHAB President Bender, board members, and workgroup members into the field to keep health departments informed about the ongoing work of developing the accreditation program, and the opportunity to submit comments and recommendations. Other PHAB staff and representatives also made presentations and conducted town halls and opens forums at partner organization meetings.

“It was really important to get information out in a personal way. We wanted practitioners and health department leaders to see the face of PHAB, and to see
that our intent was to run a program they can be proud of and have ownership in.”—PHAB’s Kaye Bender

The presentations, town halls, and open forums clearly showed that PHAB was being developed as a consensus-based organization, and let public health practitioners share their concerns and questions. “I learned a lot about what the field thought we should do, and what the practitioners thought we got right or wrong,” adds Bender. PHAB also communicated with the field through exhibits at national conferences, webcasts, a monthly newsletter, and a website (launched in 2008).

Preparing Health Departments for Accreditation

As the public health accreditation program was being developed and tested, RWJF and CDC provided funding and technical assistance to help Tribal, state, and local health departments prepare.

“This was the first time where there was support for health departments to work on things like infrastructure and make the shift to QI and being mission driven instead of a collection of services.”—RWJF’s Pamela Russo

ASTHO and NACCHO provided technical assistance and funding to state and local health departments, respectively, from 2007 to 2011 through RWJF grants.11 RWJF also funded NIHB to develop a strategy for public health accreditation in Indian country and provide technical assistance to promote and facilitate Tribal participation.12

The organizations worked together and with PHAB to align accreditation for local, state, and Tribal health departments. They also provided technical assistance to the health departments participating in PHAB’s beta test of public health accreditation and the QI projects that followed (described in the next section). NALBOH also was involved in some of this work. RWJF funded this through its national program, Providing Assistance to Public Health Agencies Preparing for Accreditation. Read the Program Results Report for more information.

QI and Accreditation

Although accreditation is a platform for advancing QI in public health practice, making the connection between accreditation and QI and determining the best ways to establish,

11 ASTHO: Grant ID 66092 ($714,598, June 15, 2009 to June 14, 2011). NACCHO: Grant ID 66077 ($1,680,000, June 14, 2009 to August 31, 2011)

12 Grant ID 63865 ($314,586, April 15, 2008 to September 30, 2009) and Grant ID 67544 ($290,075, April 1, 2010 to September 30, 2011)
spread, and deepen the use of QI was a significant challenge. Using QI requires hands-on training and coaching, which is not covered by public health schools or any other training that public health practitioners typically receive.

QI also requires a new mindset. “You have to get people to shift from their old thinking about quality assurance or quality control to thinking more of quality improvement. You have to convince people that QI will really change things,” says Russo. Leadership support for QI is also necessary.

In 2007 and 2008, as part of its program, Providing Assistance to Public Health Agencies Preparing for Accreditation, RWJF expanded a NACCHO accreditation preparation and QI program, initially funded by CDC for 10 local health departments, so it reached 56 others.\textsuperscript{13} The local health departments performed a self-assessment, using a tool developed by NACCHO, and then conducted a QI project on an issue highlighted by the self-assessment. NACCHO provided feedback to PHAB on this project, based on an evaluation of the self-assessment tool that was conducted by NORC (formerly called the National Opinion Research Center) at the University of Chicago.

Also, from 2005 to 2009, as part of Providing Assistance to Public Health Agencies Preparing for Accreditation, RWJF and CDC funded ASTHO to use its State Public Health Survey to analyze the types of programs and services health departments around the country provide.\textsuperscript{14} PHAB used the results in developing proposed state standards and measures for the national voluntary public health accreditation program. Read the Program Results Report for more information on this ASTHO project.

Public Health in Indian Country

Since Tribes are sovereign nations, public health is provided in a different way in Indian country than elsewhere. There is no single model for the structure of public health or its services. Some Tribes pay for and provide their own public health services, while others deliver these services through federal, state, or other nonprofit grants and contracts, or partner with local and state health departments to provide services.

With funding from RWJF’s Providing Assistance to Public Health Agencies Preparing for Accreditation, NIHB explored public health accreditation in Indian country and determined that it was feasible. NIHB then developed a strategic plan to implement public health accreditation and engage the Tribes in this work. NIHB also provided technical assistance to the Tribes participating in the beta test and worked with PHAB to ensure that accreditation would be relevant in Indian country. PHAB also organized a

\textsuperscript{13} Grant ID 63686 ($1,500,000, February 15, 2008 to May 31, 2009)

\textsuperscript{14} Grant ID 55274 ($233,848, December 15, 2005 to July 31, 2007), and Grant ID 58818 ($696,456, March 1, 2007 to July 31, 2009)
Tribal standards work group that provides expert consultation in the development of Tribal specific language for the standards and measures.

**CDC Support for Accreditation**

Beginning in 2010, CDC funded the National Public Health Improvement Initiative and the Accreditation Support Initiative to help prepare health departments for accreditation.

**National Public Health Improvement Initiative**

From 2010 to 2013, CDC awarded $141 million to 76 health departments through the National Public Health Improvement Initiative. The initiative is funded by and supports the Prevention and Public Health Fund of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA).

The health departments worked in three main areas:

- Efficiency: Saving time or money on program services and operations
- Effectiveness: Using practices that have been shown to work or making services and programs available to more people
- Accreditation readiness: Completing projects to prepare for applying for national accreditation

Read more about the National Public Health Improvement Initiative.

**Accreditation Support Initiative**

Since 2011, CDC has also funded the Accreditation Support Initiative, providing $3.7 million ($2.3 million in ACA funding) through November 2014. To advance accreditation readiness, CDC made small one-time grants to 61 local health departments (through NACCHO) and 17 state public health associations (through APHA). The local health departments used the funds to meet the prerequisites of accreditation (developing the community health assessment, community health improvement plan, and department strategic plan); to work on achieving the standards and measures; or to offset the accreditation fee.

Activities of the state public health associations to advance accreditation readiness included hosting educational sessions and developing toolkits, conducting gap analysis against PHAB standards and training, and developing Tribal partnerships.

In 2014, CDC also funded NIHB to support accreditation readiness in Tribal health departments and NIHB awarded small grants to five of them to work on specific steps towards achieving one or more of the standards for public health accreditation.
**Think Tanks Offer Input on Specific Areas of Public Health**

Along with the standards development workgroup and the assessment process workgroup, PHAB introduced think tanks in 2009 as another way to get input and advice from public health practitioners. The think tanks focus on three broad areas:

- Programmatic issues (traditional core program areas of public health, such as emergency preparedness and chronic disease)
- Contextual issues (the environment in which public health departments operate)
- Emerging issues (such as informatics, equity, and ethics)

“Whenever we hold these think tanks, we get advice from subject matter experts about where the field is going over the next five to seven years and how accreditation needs to reflect those changes, both in reflecting public health practice and driving change,” says PHAB’s executive director Bender.

**Testing and Releasing Accreditation Standards and Measures**

As RWJF and CDC were helping to build public health department accreditation readiness, PHAB released draft public health accreditation standards and measures, and revised them in accordance with public comment. Its beta test got underway in November 2009, and PHAB released Version 1.0 of the standards and measures in July 2011.

**The Beta Test**

PHAB chose 30 public health departments—19 local, eight state, and three Tribal—to participate in the beta test of the standards and measures and the accreditation process. Selected to represent the diversity of health departments in the United States, they varied in size, structure, population served, governance, geographic region, and degree of preparedness for accreditation.

*"The beta test was critical in us being able to begin this journey."*—Laura Sawney-Spencer, MPH, CPH, Cherokee Nation Health Services

RWJF urged the beta test health departments to do a QI project to reinforce the relationship between pursuing accreditation and QI. The Foundation funded ASTHO and
NACCHO to provide technical assistance and monetary support to participating health departments and NIHB provided technical assistance to facilitate Tribal participation. Throughout the beta test, the participating health departments provided feedback to staff at PHAB on the process, materials, and tools. NORC at the University of Chicago also evaluated all but the QI portion of the beta test. PHAB used the feedback and evaluation findings to further modify the accreditation process and the standards and measures.

PHAB staff also provided training both to the participating health departments on the beta test accreditation process and to ASTHO, NACCHO, NALBOH, NIHB, the Public Health Foundation, and the National Network of Public Health Institutes on ways to provide technical assistance to health departments seeking accreditation.

**Communication During and After the Beta Test**

PHAB stepped up communication efforts around the time of the beta test, when Bender and board members spent a great deal of time in the field allaying concerns about accreditation. They continued this through the release of the standards.

Much of the communication focused on how health departments could work on accreditation when they were dealing with severe funding and staff cutbacks due to the recession. Close to the launch of public health accreditation in September 2011, PHAB staff also had to convince some state and local health departments, particularly those in the Midwest, that public health accreditation was not part of the still-controversial Affordable Care Act.

**The Standards and Measures and the Accreditation Process**

In July 2011, PHAB released Version 1.0 of the practice-focused, and evidenced-based standards to assess the performance of health departments. It also released a guide describing the accreditation process. The standards are organized into 12 domains:

- 10 domains on the Essential Public Health Services, listed in Appendix 3
- One domain on management and administration
- One domain on governance.

Each domain has at least two standards that reflect the level of achievement required for accreditation. The health department must provide documentation showing how it meets the measures for each standard. See Appendix 4 for a list of the domains.

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15 ASTHO: Grant ID 66092 ($714,598, June 15, 2009 to June 14, 2011); NACCHO: Grant ID 66077 ($1,680,000, June 2009 to August 2011)
16 Grant ID 67544 ($290,075, April 1, 2010 to September 30, 2011)
The standards apply to the overall infrastructure of the health departments and are intended to help them demonstrate their capacity to manage any public health program. Since health departments vary in scope of activity, size, governance, and other factors, the standards do not prescribe how a health department meets a particular measure.

The domains and standards are the same for Tribal, state, territorial, and local health departments, but there is some variation in the measures. For each measure, PHAB describes the purpose, significance, required documentation, and guidance on preparing and submitting the documentation. Health departments use a Web-based electronic information system called e-PHAB to apply for accreditation and PHAB uses e-PHAB to manage the accreditation process.

In December 2013, updated Standards (Version 1.5) were adopted. Read more about the current Standards (Version 1.5, which was adopted in December 2013 and applies to applications submitted starting June 3, 2014). The update clarifies the wording of requirements and specifies the number of examples that are required and the time frame for each measure. It also adds or emphasizes some issues that are emerging as important forces in advancing public health, such as health equity, public health ethics, and informatics.

The Accreditation Process

Read more about the accreditation process:

- *Guide to National Public Health Department Accreditation, Version 1.0*
- Seven Steps of Accreditation on PHAB’s website

The Accreditation Fee

As PHAB was considering the accreditation application fees, its survey of health departments indicated that the proposed fee could be a barrier for health departments, given the recent effects of the economic downturn on government budgets.

PHAB needed to plan for its long-term sustainability and had built a modest reserve fund into its formula for the initial fee structure. But RWJF viewed more affordable fees as critical to the success of the accreditation program and gave PHAB a grant to establish a more robust reserve fund in November 2011. With the fund in place, PHAB was able to

17 The early results of the accreditation program covered in this report are based on Version 1.0.
18 Grant ID 69361 ($1,200,000, November 1, 2011 to October 31, 2015)
keep its fees lower than they otherwise would have been, and to commit to not increasing the fees through at least 2016.

**EARLY RESULTS OF THE PUBLIC HEALTH ACCREDITATION PROGRAM**

RWJF, CDC, and PHAB offer these highlights of the launch and early years of the public health accreditation program (through December 2014). The *Journal of Public Health Management and Practice* published a free special accreditation issue that has more information (January/February 2014).

**PHAB Launches the Public Health Accreditation Program**

With the help of 400 public health practitioners, PHAB launched the first national accreditation program for all public health departments in September 2011.

> “Accreditation sets a benchmark of consistent standards for public health services that should be met in every community. It creates a platform for quality improvement and provides a means of documenting accountability to the public and to policymakers.”—RWJF’s Pamela Russo

By serving as a catalyst for QI and strengthening public health services and infrastructure, “accreditation has a huge opportunity to be transformative to public health,” says CDC’s Corso. Other benefits include increased accountability, visibility, and credibility for public health.

The participation of about 400 public health practitioners and major public health associations in crafting the standards and measures ensured their relevance to health departments. Having “folks who were walking the walk and talking the talk” develop the program resulted in “credibility and acceptability amongst the public health community,” says Mary Kushion, MSA, a member of the standards development workgroup.

> “It’s important to have that boots on the ground applicability.”—Terry L. Cline, PhD, Oklahoma Commissioner of Health
205 Million Americans Have a Health Department that is Accredited or Has Applied for Accreditation

Nearly 205 million Americans—about 66 percent of the total population—are served by either an accredited health department or a health department that has applied for accreditation (as of December 2014).

The first 11 health departments were accredited in February 2013. Since then, a total of 49 additional health departments have been accredited, for a total of 60 health departments (as of December 2014).

“Residents of a community served by a nationally accredited health department can be assured that their health department has demonstrated the capacity to protect and promote the health of that community.” — PHAB’s Kaye Bender

A total of 311 departments are accredited or have applied for accreditation:

- 28 state and territorial health departments (7 are accredited and 21 are in the accreditation process)
- 283 local health departments (53 are accredited and the rest are in the accreditation process). They include:
  - 67 local health departments within one already-accredited state that are going through the accreditation process together as a centralized state integrated system
  - 4 local health departments that often work together (multijurisdictional health departments) have applied as a multijurisdictional applicant. While they share documentation, each of the four health departments will receive accreditation (or none will).
  - 2 Tribal health departments are in the accreditation process.

The smallest health department that has been accredited or applied for accreditation serves 725 people while the largest serves about 37.7 million people.

“As health departments have started to get accredited, people began to understand what it is and that it can be done by a range of health departments, including the smallest. It’s a lot of work, but what we hear from everyone who’s gone through it is that it was worth it. They see qualitative benefits of accreditation.” — RWJF’s Pamela Russo
“We are going to use our accreditation credential to show our community that we’re worthy,” adds Torney Smith, MS, administrator of the Spokane Regional Health District, (Spokane, Wash.). The Spokane Regional Health District was in the first group of health departments to become accredited in February 2013.

See Appendix 5 for a list of accredited health departments as of December 2014.

**Highlights From Accredited Sites**

**Accreditation in a State Health Department**

**Oklahoma**

Oklahoma, whose health department serves about 3.8 million people, was one of the first states to be accredited in 2013 (along with Washington state). Three local health departments in Oklahoma were accredited the same year and Cherokee Nation Public Health began the accreditation application process in November 2014.

> “Being among the first to achieve national standards that promote continuous quality improvement demonstrates that we are delivering services as effectively as possible.”—Terry L. Cline, Oklahoma Commissioner of Health

Within the Oklahoma State Department of Health, accreditation has increased awareness of the value of QI and enabled the state health department to move closer toward a culture of QI. “Accreditation provides a vehicle to launch a cultural shift within the organization. It’s a great way to leverage existing resources and improve performance without additional costs of adding programs or other activities,” says Cline.

In 2013 and 2014, the Oklahoma State Department of Health received the Quality Crown Award, the top QI award given by the state, for:

- **The data management system:** Used to inform activities and decision-making, the system includes goals, timelines, and the name of the person responsible for each task. It is updated and monitored regularly to determine progress, or lack thereof, toward each goal.

- **Reducing overuse of antipsychotic medicines in nursing home residents with dementia:** Working with nursing homes, advocates, families, and providers, the department was able to reduce overuse of antipsychotics in residents with dementia by 24 percent, exceeding the goal of 15 percent.

As part of the accreditation process, Cline and the six other senior leaders read every policy and procedure and discussed them at weekly meetings. They updated outdated
policies and procedures, eliminated unnecessary policies or procedures, and added new policies or procedures, for example, related to social media and the dress code.

Read more about the Oklahoma State Department of Health’s accreditation experience in the *Journal of Public Health Management and Practice* (January/February 2014).

**First Local Health Departments to be Accredited**

The Chicago Department of Public Health, Central Michigan District Health Department (Mt. Pleasant, Mich.), and Three Rivers District Health Department (Owenton, Ky.) were among the local health departments accredited by PHAB in the first year.

**Chicago**

Chicago, which has about 2.7 million people, was the first big city to have an accredited health department.

“This was an opportunity for us to be a leader in public health, and a model for other health departments in our state and in big cities across the country to show that this could be done.”—Jaime Dircksen, BA, AM, Deputy Commissioner, Chicago Department of Public Health

The focus on QI, workforce development, and performance management has increased significantly in Chicago. “We’ve infused QI throughout the department and helped folks understand the importance of performance improvement and QI from a positive perspective, not a punitive perspective,” said Dircksen.

Health department activities included employee satisfaction surveys and mandatory bimonthly management training for managers. A 2014 review of the performance management system showed that the majority of staff members were using performance management and QI.

Among other concrete improvements in public health services as a result of the focus on gathering data and using it in decision-making, is that HPV vaccination rates among adolescents have increased. The department received a CDC grant of $750,000 for the immunization program.

Read more about Chicago’s accreditation experience in the *Journal of Public Health Management and Practice* (January/February 2014).
Central Michigan

The Central Michigan District Health Department, which serves 191,000 people in six counties (Arenac, Clare, Gladwin, Isabella, Osceola, and Roscommon), was the first local health department in Michigan to be accredited. “Being accredited was a validation of our work and the efforts we put into it. It elevated the reputation of the health department within our state,” says the department’s former Health Officer, Kushion.

The Central Michigan District Health Department had never done a community health assessment plan or a community health improvement plan until it began the accreditation process. Each county established a team of stakeholders to work on its plans.

As a result of developing these plans, in 2012, the Central Michigan District Health Department received a CDC Community Transformation Grant of $1.6 million to improve health status in medically underserved communities in Central Michigan. The Together We Can (TWC) Transform Central Michigan Communities Program focuses on reducing the rate of obesity by improving nutrition and increasing physical activity; and reducing death and disability due to heart disease, stroke, and tobacco use.

Three Rivers District, Kentucky

The Three Rivers District Health Department serves about 50,000 people in four rural Kentucky counties (Carroll, Gallatin, Owen, and Pendleton). District Director Georgia Heise, DrPH, was looking for standards on an ideal health department for the department’s strategic plan. “Accreditation fit the bill,” she says. “The PHAB standards are a playbook of how to run a health department.”

Establishing a culture of quality and increasing grant funding for QI work are key benefits of accreditation for the department. “We have employees who feel empowered to take a look at the job and if there’s something they feel can be done better, more effectively, or more efficiently, they have a vehicle to make that happen. Before we went down the accreditation path, that was not the case,” says Heise.

Since becoming accredited, the Three Rivers District Health Department has also participated in other projects to improve quality. For example, the National Network of Public Health Institutes selected it as one of 10 health departments to participate in a weeklong QI and “kaizen event” training as well as onsite coaching. This project was funded by RWJF.

Kaizen means “change for the better.” A kaizen event is a team-based approach in which a team uses all phases of the QI cycle effectively and rapidly to make improvements. The

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19 The Community Transformation Grants help communities design and carry out local programs that prevent chronic diseases such as cancer, diabetes, and heart disease.
Three Rivers District Health Department focused on developing a better operating system during its kaizen event.

**Tribal Accreditation**

The Cherokee Nation runs the largest tribally-operated health care system in the United States, serving more than 317,000 citizens in a 14-county Tribal jurisdiction service area in Oklahoma, as well as Tribe members living in other states.

The Cherokee Nation Health Services participated in the beta test and was the first Tribe to apply for accreditation. “The Cherokee Nation prides itself on being trailblazers. We want to show the other Tribes that accreditation is doable,” says Laura Sawney-Spencer, MPH, CPH, of the Cherokee Nation Health Services.

Preparing for accreditation enabled the Cherokee Nation Health Services to develop, for the first time, a solid, functional public health infrastructure, making the system more accountable and transparent. It has also increased acceptance of public health by health care providers working for the Cherokee Nation Health Services, setting the stage for greater cooperation. “Accreditation will be the tool that will allow the Tribes to be able to reduce disease burden, save lives, and improve the quality of life for Tribal people,” says Sawney-Spencer, who is also a PHAB site visitor.

Sawney-Spencer and colleagues at the Cherokee Nation Health Services are already promoting accreditation among other Tribes, and are starting to provide them with technical assistance. Cherokee Nation Health Services also plans to help state and local health departments with large populations of native people.

**EVALUATION OF THE ACCREDITATION PROGRAM**

To continuously improve the accreditation program, PHAB conducts internal and external evaluation activities, guided by its evaluation and quality improvement committee and the research advisory council.

“We ask health departments to engage in QI and we hold ourselves to the same standard. We focus on evaluation and QI ourselves.”—Jessica Kronstadt, MPP, Director of Research and Evaluation at PHAB

**Internal Evaluation**

PHAB’s internal evaluation began in 2011 and focuses primarily on evaluating the processes used in the accreditation program through surveys of health departments and site visitors, evaluations completed by participants in PHAB training programs, and
surveys of PHAB’s accreditation specialists. The internal evaluation also asks health departments whether they made the right decision in deciding to apply for accreditation, and whether the process improved their performance.

PHAB uses information from the internal evaluation to strengthen its processes. “PHAB is constantly seeking others’ opinions on how to make the process better, what should be included in the next set of standards and measures, and the evolving role of public health for the nation,” says Kushion, former health officer at the Central Michigan District Health Department and a member of the standards development workgroup.

**External Evaluation**

NORC at the University of Chicago is conducting the external evaluation, with funding from RWJF and CDC. The three-year evaluation began in 2013. Michael Meit, MA, MPH, program area director for public health at NORC, is the lead evaluator.

The evaluation focuses on assessing ongoing accreditation activities and processes and the quality of these experiences. Evaluators have been gathering data from the health departments through:

- Surveys after the health department submits its statement of intent to apply for accreditation, after it is accredited, and a year later
- Interviews with health department staff and other stakeholders, including board of health members and representatives of partner organizations, such as those that participate in the community health assessment and health improvement plan

Future evaluations will include additional features, such as focus groups and additional interviews.

**Annual Reports**

PHAB uses the annual reports that accredited health departments must submit to ensure their continued conformity with the standards and measures and support them in advancing their QI culture and preparing for re-accreditation. The annual reports cover:

- Any changes that might affect the health department’s accreditation status
- Standards and measures on which the health department continues to work
- An update on their QI activities and work on their community health assessment, community health improvement plan, strategic plan, and QI plan

“We view the annual report as a real opportunity for QI,” says PHAB’s Kronstadt. “The evaluation and quality improvement committee provides feedback to help the health department.”
Evaluation Findings

Evaluators at NORC and PHAB reported these findings:

The Decision to Pursue Accreditation

- Of the 10 health departments surveyed by NORC shortly after becoming accredited, all agreed or strongly agreed that applying for accreditation was the right decision. Of the nine health departments that responded to the survey one year after they were accredited all agreed or strongly agreed that applying for accreditation was the right decision.

- Almost all of the 63 health departments (97%) surveyed by PHAB after the site visit, but before the accreditation decision, agreed or strongly agreed that their health department made the right decision to pursue accreditation.

- The accreditation process met the expectations of the 15 health departments that were interviewed by evaluators about their accreditation experience in terms of fostering QI, increasing department professionalism, and enhancing knowledge about the health department and its jurisdiction.

- Applicants were glad they completed the accreditation process and found it to be rewarding. Receiving validation that they are doing their activities well was the most rewarding part of the process for many health departments.

Increased Focus on QI and Performance Improvement

- All of the health departments strongly agreed or agreed that going through the accreditation process improved their performance, according to PHAB surveys of accreditation coordinators in 63 health departments.

  One year after becoming accredited, all or most of the 17 health departments surveyed stated that they have:

  - Implemented or planned to implement new strategies for QI (100%)
  - Used or planned to use information from their QI processes to inform decisions (94%)
  - Developed a strong culture of QI (88%)

Benefits of Accreditation

Almost all (94%) of the 17 accredited health departments surveyed by NORC reported that accreditation had:

- Helped them identify strengths and weaknesses
- Helped them document capacity to deliver core functions and the 10 essential services of public health
• Stimulated greater accountability and transparency
• Improved management processes used by the leadership team
• Stimulated QI and performance improvement opportunities

The greater transparency is especially important, says PHAB’s Bender.

“There is a lot of talk a lot about lack of trust in government and the desire to downsize government. When a health department comes forward and says it volunteered to go through the accreditation process to be accountable to the policymakers and public, that resonates very well.”—Kaye Bender, Director of PHAB

Among accredited health departments, other stated benefits are:

• Improved accountability to external stakeholders (76.5%)
• Improved communication with the board of health or governing entity (64%)
• Improved competitiveness for funding (47%)

**Satisfaction With PHAB**

• **Health departments that have applied for accreditation are generally positive about their interactions with PHAB**, according to NORC evaluators:
  — After submitting their statement of intent to apply for accreditation, 73.8 percent of the 84 health departments surveyed strongly agreed or agreed that they were satisfied with the amount of interaction they had with PHAB staff.
  — Of the 68 health departments surveyed after the site visit but before the accreditation decision, 97 percent agreed or strongly agreed that they received answers to questions from PHAB in a timely manner and got the information they needed.
  — A few respondents expressed frustration about how slow the entire accreditation process was, leading PHAB to develop a more systematic process—including templates for email communication—for PHAB accreditation specialists to reach out to health departments and site visitors to expedite each step in the process, where possible.
  — All of the surveyed health departments agreed that they could use e-PHAB effectively.
  — All of the site visitors also agreed or strongly agreed that they received the information they needed, and had their questions answered in a timely manner.
SIGNIFICANCE OF THE PROGRAM

The establishment of PHAB and public health accreditation helped to strengthen the public health infrastructure.

Growing the Momentum for Public Health Accreditation

With 29 states either accredited or somewhere in the accreditation process, accreditation has reached a “tipping point,” says CDC’s Corso. Health departments are evolving to learn how to meet the accreditation requirements—and why it is important to do so. Early consternation about developing community health assessments, community health improvement plans, and a department strategic plan, for example, has turned into an understanding that this is the foundation for everything else health departments do.

Even health departments that have not yet applied for accreditation are developing those documents.

“Just the existence of the standards is having a big impact. I think of that as the stealth impact of accreditation. This impact occurs long before health departments apply for accreditation and it’s harder to measure.”—Liza Corso, Centers for Disease Control and Prevention

RWJF and CDC funding was crucial in enabling health departments to work on their infrastructure and “make the shift to being mission driven instead of a collection of services,” says Russo.

Greater Health Department Focus on Mission and a Consistent Framework

Rather than a silo mentality driven by funding sources, health departments pursuing accreditation now use the 10 essential public health services as a framework for organizing, implementing, and evaluating their work, and take “a broader, more comprehensive approach to their work as a whole,” says PHAB’s Bender.

“There’s a much greater understanding of the importance of being mission driven and how that gives you the power to make better decisions about how to allocate funds, be efficient, get rid of waste through QI, be more customer oriented, and emphasize partnerships.”—Pamela Russo, RWJF
Catalyzing QI and Performance Management

Health departments either established or strengthened their QI activities as part of the accreditation process. “Accreditation really jump-started QI,” says Russo. Health departments are also developing performance management systems.

Increasing the Visibility and Accountability of Public Health

Public health has become more visible to policymakers and the public now, say Russo, Corso, and Grace G. Gorenflo, MPH, RN, a consultant to PHAB. This is crucial to maintaining funding and support for health departments. Accredited health departments are “better positioned to show policymakers the sound investment they’re making in public health,” says Gorenflo.

“Acreditation is the assurance to the public, taxpayers, legislators, and the community that they have a quality health department that is doing quality public health work.”—Terry L. Cline, Oklahoma State Department of Health

“Accreditation means taxpayers can rest assured that their money is being spent in the best possible way. It makes us accountable to them,” adds the Three Rivers District Health Department’s Heise.

Establishing PHAB as a Leader

PHAB has become a public health leader since it was established in 2007. “That’s a huge accomplishment in a short period of time,” says CDC’s Corso.

“The evolution has been very fast, from nothing to a well-oiled machine,” adds Robin Wilcox, MPA, chief program officer at PHAB. “We’re engaged in continuous development and implementation, and at the same time we’re evaluating what we do and we’re growing. We’re a learning organization that is well organized and focused. Our staff is highly motivated to do a good job.”
LESSONS LEARNED

Many challenges and lessons learned about establishing PHAB, aligning QI and accreditation, and launching the public health accreditation program have been described earlier in this report. Others reported are:

Lessons About Preparing for Accreditation

1. **Identify strategies to convince health department staff that accreditation is worth the work.** Convincing staff members “that the juice is worth the squeeze,” that if they put in the time to become accredited, it will be worth it, is a challenge, says RWJF’s Russo. “It’s a lot of work, but what we hear from everyone who’s gone through it is that it was worth the squeeze. They see qualitative benefits of accreditation.”

   Russo notes that many accredited health departments have tried to make the process fun, rather than drudgery. Some health departments have introduced games and prizes to engage staff members. Having a champion within the health department who is innovative in explaining how accreditation will benefit the health department in the long run is critical.

2. **Develop incentives for health departments to pursue accreditation.** Russo notes that CDC has been very creative in this area. CDC has changed its standard funding opportunity template to include language about accreditation and has allowed health departments to use some funds from other CDC programs to support their accreditation preparation. CDC’s National Public Health Improvement Initiative, which ended its funding in September 2014, for example, provided a financial incentive for health departments to work on accreditation and QI. CDC’s block grants can also be used for activities such as supporting accreditation standards and capabilities.

   “Now that we’re getting an increasing number of health departments interested in accreditation, we need to think more seriously about incentives for accreditation status,” says CDC’s Corso. “That’s something we’re working on with RWJF and internally.”

3. **Recognize that aligning QI and accreditation is difficult.** RWJF, CDC, and PHAB are all involved in promoting this alignment. While accredited health departments have come a long way in this area, there is still much to do to make QI a regular part of health department culture. (Reports to RWJF)

Lessons About Developing a Complex Program

4. **Balance faster program development against the need to thoroughly consider, test, and vet a program.** The standards workgroup would have benefited from more time to carefully consider its work at each step and a longer public comment period. PHAB’s Bender notes that some of the clarifications in Version 1.5 of the standards
and measures might then not have been necessary, and PHAB might have been able to provide clearer education to health departments about what to consider before they applied for accreditation.

5. **Involve users throughout program development.** The involvement of public health practitioners in developing the public health accreditation program built support by ensuring that “the end product is owned by them,” said PHAB in a report to RWJF. “PHAB believes that a program built upon a consensus model has the most potential for sustaining itself long-term.”

**Lessons About Documentation Requirements**

6. **Develop strategies to meet the resource-intensive requirements for documentation.** Developing the documentation required for accreditation is often difficult. “We relied on oral history, but if someone retired, you lost that chunk of oral history,” says Oklahoma’s Cline. Oklahoma eventually completed its documentation by putting the accreditation coordinator in charge of the process, and spreading the work out among a group of people who had to meet aggressive timelines.

“It’s really hard for health department employees to get everything done and labeled and packaged the way PHAB wanted them to do it,” adds Three Rivers District Health Department’s Heise. Using an accreditation team made up of front-line staff to develop documentation worked for her department. Other front-line staff members were more willing to complete the documentation when the request came from their peers, rather than managers.

Jurisdictional issues and lack of a strong public health infrastructure make documentation requirements especially difficult for Tribes. “The state and local health department people need to know that it’s not that Tribes don’t want to become accredited; they don’t have the resources,” says Sawney-Spencer of Cherokee Nation Health Services. More collaboration between state, local, and Tribal health departments will be necessary to facilitate Tribal accreditation.

For more lessons about the experiences of 11 health departments at various stages of the accreditation journey, read the case reports in the *Journal of Public Health Management & Practice’s* 2014 special issue on accreditation.

**THE WORK GOING FORWARD**

**PHAB**

PHAB will continue to evolve the public health accreditation standards and processes to reflect the field’s consensus view on how accreditation can best advance public health performance. Ways of gathering feedback from the field include providing opportunities to vet the standards and measures; creating discussion forums at national and regional
meetings; and soliciting input from site visitors and health departments that apply for accreditation.

“Continuing to grow the number of health departments applying for accreditation” is also a key goal, says Bender. Re-accreditation of accredited health departments will begin in 2018. PHAB will begin to develop the re-accreditation process in 2015.

Planning for Sustainability

PHAB developed a long-term business plan and expects to be mostly self-sustainable, with some federal grant support, by 2016. Along with accreditation fees, PHAB will generate revenue through custom accreditation programs, specialized accreditation tracks, and other possible “books of business,” says Bender. In 2014, for example, PHAB began working with the U.S. Department of Defense to develop standards and measures for public health services at 33 local army installations.

PHAB is also working on an optional specialized accreditation track for vital statistics units of state health departments. The organization will develop other specialized accreditation tracks based on input from the public health field or CDC.

RWJF

Building a Culture of Health, RWJF’s overarching goal, means building a society where getting and staying healthy is a guiding social value. Improving the quality and efficiency of public health is an important part of that. RWJF is committed to continuing support of public health accreditation and QI to improve the impact of health departments, and to engaging public health with other cross-sector partners, to foster a Culture of Health in their communities.

“Our hope is that the next Future of Public Health committee will find that public health is no longer in disarray. Instead, what will have emerged is that people and policymakers understand the value and role their health department plays in conducting high-quality practices that improve, protect, and promote the health of all community members,” say Russo and RWJF director Paul L. Kuehnert, DNP, RN.

RWJF also is funding NORC to conduct an evaluation on the state of accreditation and its impact on health departments beginning in February 2015. The evaluation will measure and describe the early effects of PHAB, focusing on QI activities and outcomes, transparency, intra-agency and cross-sector collaboration, changes in agency budget allocations related to accreditation, and unintended consequences of accreditation.

While CDC funding is determined from year to year, Corso plans to work with colleagues and leadership to ensure that PHAB and public health accreditation continue to be a priority. “We have a continued interest in supporting PHAB and other partners in regards to accreditation readiness,” she says. CDC funding of PHAB will continue to focus on continuous improvement of the accreditation program; updating the standards and measures; evaluation; and communication and training.
APPENDIX 1

RWJF’s Notable Early Investments in Improve the Public Health System

Turning Point

*Turning Point: Collaborating for a New Century in Public Health®* was a joint effort by RWJF and the W.K. Kellogg Foundation that ran from 1996 to 2006. It sought to “transform and strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative.” Some 22 states and 41 communities in those states worked together to strengthen their public health systems and develop health improvement plans.

In the second phase of *Turning Point*, the grantees formed five collaboratives focused on key challenges. The Performance Management Collaborative was particularly important in laying the foundation for future accreditation work. It developed a four-component performance management model that continues to provide an important framework for improving public health performance.

The components are:

- **Performance standards**: Establishing organizational or system performance standards, targets, and goals and relevant indicators to improve public health practice
- **Performance measures**: Applying and using performance indicators and measures
- **Reporting progress**: Documenting and reporting progress in meeting standards and targets, and sharing that information through feedback
- **Quality improvement**: Establishing a program or process to manage change and achieve quality improvement in public health policies, programs or infrastructure based on performance standards, measurements, and reports

See the Program Results Report for more information.

Development of a Common Operational Definition

The National Association of County and City Health Officials’ *Operational Definition of a Functional Local Health Department*, published in November 2005 described what public health practitioners and the communities they serve can reasonably expect from local health departments and then set standards for accountability. The standards later became part of the foundation of the national voluntary accreditation standards. RWJF
funded this work through four grants totaling $860,000 to the association;\textsuperscript{21} CDC contributed $600,000.

See the Program Results Report for more information.

**APPENDIX 2**

**RWJF Work to Support Accreditation and QI**

*The Community of Practice for Public Health Improvement*

*The Community of Practice for Public Health Improvement* program, which began in October 2011 and is currently funded through September 2016, is about building “capacity and the passion for shared learning to propel public health departments in the drive for accreditation and quality improvement,” says RWJF’s Russo. The National Network of Public Health Institutes manages the program.

The program continues the twice-yearly open forum meetings that were part of the *Multistate Learning Collaborative*. Through these meetings, public health practitioners and experts in public health and other fields share information about preparing for accreditation and best practices in QI. The open forum meetings, which include pre-meeting training workshops, draw participants from all 50 states as well as the territories, and Tribes.

Other components of *the Community of Practice for Public Health Improvement* include:

- *Shared learning through QI awards and individualized QI coaching* to 60 public health departments. The QI Awards program helped selected health departments prepare for accreditation by giving them small grants of $5,000 apiece to conduct a QI project designed to result in measurable change.

- *Gaining Ground*, a two-year initiative to help seven states develop sustainable, statewide systems to catalyze public health accreditation and support performance improvement in their local, tribal, and state health departments.\textsuperscript{22}

State coalitions in California, Colorado, Iowa, Nebraska, New Jersey, North Dakota, and Utah are each receiving $150,000 and individualized coaching to prepare for accreditation. Each state coalition is comprised of state, local, and Tribal health departments, and other key stakeholders including public health institutes and schools of public health. Read more about *Gaining Ground* on NNPHI’s website.

In addition, RWJF provided funding for NACCHO to provide leadership training sessions to health directors in the Gaining Ground sites on how best to lead an

\textsuperscript{21} Grant IDs 50045, 52324, 52676, 57248 (February 1, 2004 to July 31, 2008)

\textsuperscript{22} Grant ID 71449 ($2,082,453, December 15, 2013 to June 14, 2016)
organization to embrace change, advance a culture of quality improvement and pursue accreditation.\textsuperscript{23}

- The Kaizen Event, in which NNPHI and Continual Impact, LLC (Kempton, Pa.), led 10 health departments in a week-long QI and “kaizen event” training. Held in 2013, the event was followed by onsite coaching so that each health department could conduct their kaizen event.\textsuperscript{24} A kaizen event is a team-based approach in which a team uses all phases of the QI cycle effectively and rapidly to make improvements.

Read more about the Kaizen Event Program on NNPHI’s website.

- PHAB QI Academy, launched in late 2014, is designed to develop leaders in public health QI who can guide accredited health departments in establishing a culture of quality.\textsuperscript{25}

PHAB will select 12 QI leaders from accredited health departments. Continual Impact, LLC, will deliver the program, which includes training in foundational QI skills, and in the kaizen event process and techniques, followed by on-site coaching.

The 10 health departments that participated in the kaizen event program will then join the 12 QI leaders for training on how to identify key organizational opportunities through a comprehensive annual QI planning process, change management, and awareness of more advanced QI methods and concepts. Each health department will then receive on-site coaching and will complete at least four QI projects. After the training is completed, PHAB will continue the community of QI leaders.

Read the Program Results Report on Strengthening the Community of Practice in Public Health Improvement program.

**Public Health Quality Improvement Exchange**

*Public Health Quality Improvement Exchange*\textsuperscript{26} (PHQIX.org) is a searchable online database that organizes information from public health quality improvement projects. In 2012, RWJF began funding the exchange to provide a single place where health departments could search for QI projects on specific topics or learn how various QI tools had been applied; funding continues into March 2016. The Research Triangle Institute in Research Triangle Park, N.C., is managing PHQIX, which started with 50 projects and sophisticated search capabilities.

\textsuperscript{23} Grant ID 71690 ($260,000, April 1, 2014 to September 30, 2015)
\textsuperscript{24} Grant ID 71216 ($418,134; September 15, 2013 to January 14, 2015)
\textsuperscript{25} Grant ID 72340 ($823,800; December 15, 2014 to February 14, 2016)
\textsuperscript{26} Grant ID 69839 ($1,999,912; March 15, 2012 to March 14, 2014), and Grant ID 71647 ($1,797,187, March 15, 2014 to March 14, 2016).
User response exceeded expectations and public health departments are submitting many projects. PHQIX has fostering an online community for public health QI where exchange users can:

- Submit a QI initiative,
- Search existing quality improvement interventions and tools,
- Start a discussion or chat with an expert
- Ask questions about the development and execution of QI initiatives.

RWJF owns the database, website, and associated software, and will identify the most appropriate home for the website at the end of the grant period to ensure access and sustainability.

Read the Program Results Report on the work of the Public Health Quality Improvement Exchange through early 2014.

**Helping Health Departments Prepare for Accreditation and QI**

RWJF has also funded other work related to accreditation and QI:

- Community health assessment and improvement plans
- QI at five state health departments
- *Advancing Accreditation in Large Jurisdictions*
- Quality Improvement Forum
- Center for Sharing Public Health Services.

**Community Health Assessment and Improvement Plans**

NACCHO helped 12 local health departments prepare for accreditation by completing the community health assessments and community health improvement plans that are prerequisites for accreditation. NACCHO also developed resources on developing community health assessments and health improvement plans for other health departments, including the assessments and plans developed by the 12 health departments, webinars, and a checklist. For more information read the Program Results Report.

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27 Grant ID CHA ($1,495,971; December 1, 2010 to June 30, 2013).
QI at Five State Health Departments

ASTHO worked with five state health departments (Arizona, Connecticut, Maryland, Minnesota, and Oregon) on QI projects to help them prepare for national accreditation. The QI projects focused on three key program areas: environmental health, chronic disease and prevention, and maternal and child health.

Four of the five states showed improvement in their project area; the fifth state completed its tests of change after the grant ended. Each state submitted their QI projects to PHQIX and submitted five examples of documentation demonstrating compliance with the PHAB standards and measures.

Read the Program Results Report to learn more. Results from the state that completed its work after the grant period are not included in this report.

Advancing Accreditation in Large Jurisdictions

Health departments in 10 big states and cities are accelerating their progress toward accreditation as part of Advancing Accreditation in Large Jurisdictions. Launched in 2012, this program gives the participating health departments funding and targeted technical assistance to complete the accreditation process. The health departments are also developing accreditation tools that other states and cities can use. ASTHO and NACCHO are providing technical assistance and facilitating knowledge sharing.

Read the Progress Report on Advancing Accreditation in Large Jurisdictions.

Quality Improvement Forum

After CDC and other federal agencies that were participating in a meeting sponsored by RWJF agreed that cross-agency exchange of QI efforts was needed, RWJF started the Quality Improvement Forum. Under the first grant, managed by ASTHO and Continual Impact, LLC, (Kempton, Pa.), representatives from federal agencies and state and local health departments came together to exchange QI knowledge and prioritize QI projects to improve federal programs delivered at the state and local levels.

Grant ID 69098 ($121,026; June 15, 2011 to June 30, 2012) and Grant ID 69394 ($816,843; November 15, 2011 to November 14, 2013).

Grant ID 70355 to ASTHO ($115,000; September 14, 2012 to August 31, 2014).
In the current phase of the Quality Improvement Forum, teams from federal, state, and local public health departments are working together on four priority QI projects identified during the first forum:

- Improving the transfer of timely, applicable, and accurate data from state to local health agencies, using vital statistics as an example
- Improving the efficiency, effectiveness, and consistency of program-reporting requirements for new grants from multiple federal agencies
- Improving the grant application process by collecting applicant feedback and developing a clearer, streamlined, standardized, and effective process for funding opportunity announcements
- Promoting and funding the use of QI as part of grants from federal agencies for specific programs.

Continual Impact LLC provides QI coaching and technical assistance while ASTHO helped identify the participants and coordinates the project and forum meetings. ASTHO will also handle communication of forum results.

**Center for Sharing Public Health Services**

Cross-jurisdictional sharing—from handshake agreements to full-scale consolidation or mergers—enables health departments to collaborate and share capacity and services to improve their efficiency and effectiveness.

The **Center for Sharing Public Health Services**, managed by the Kansas Health Institute, a policy organization based in Topeka, Kan., is a resource for cross-jurisdictional sharing. Launched in 2012, the center focuses on developing collective knowledge of what works and under what circumstances.

The center is collecting evidence from 16 teams that are using cross-jurisdictional sharing and are part of its Shared Services Learning Community. The experience of these teams, along with other research and expert opinions, are providing knowledge and tools that the center will share with other interested health departments. The website offers resources such as a roadmap to cross-jurisdictional sharing and webinars.

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APPENDIX 3

The 10 Essential Public Health Services

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
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.
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 health and personal health care workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
10. Conduct research to gain new insights and identify innovative solutions to health problems.

APPENDIX 4

PHAB’s Twelve Domains

Note: This information is from Version 1.5 of the standards, adopted in December 2013. The domains are the same as in Version 1.0, except for a few minor changes in the language used to describe them.

- Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.
- 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.
• Domain 8: Maintain a competent public health workforce.
• Domain 9: Evaluate and continuously improve 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 5

Accredited Health Departments Organized by State

California
• California Department of Public Health, Sacramento
• Ventura County Public Health, Oxnard

Colorado
• El Paso County Public Health, Colorado Springs

Connecticut
• Norwalk Health Department, Norwalk

Florida
• Florida Department of Health, Tallahassee

Illinois
• Champaign-Urbana Public Health District, Champaign
• Chicago Department of Public Health, Chicago
• Cook County Department of Public Health, Oak Forest
• DuPage County Health Department, Wheaton
• Kane County Health Department, Aurora
• St. Clair County Health Department, Belleville

Kansas
• Johnson County Department of Health and Environment, Olathe
• Sedgwick County Health Department, Wichita
Kentucky
- Barren River District Health Department, Bowling Green
- Franklin County Health Department, Frankfort
- Green River District Health Department, Owensboro
- Lexington-Fayette County Health Department, Lexington
- Madison County Health Department, Richmond
- Northern Kentucky Independent District Health Department, Edgewood
- Three Rivers District Health Department, Owenton

Louisiana
- New Orleans Health Department, New Orleans

Maryland
- Frederick County Health Department, Frederick
- Worcester County Health Department, Snow Hill

Michigan
- Central Michigan District Health Department, Mount Pleasant
- Kent County Health Department, Grand Rapids

Minnesota
- Hennepin County Human Services and Public Health Department, Minneapolis
- Minnesota Department of Health, St. Paul

Missouri
- Kansas City Missouri Health Department, Kansas City

Montana
- Missoula City-County Health Department, Missoula
- RiverStone Health, Billings

New York
- Livingston County Department of Health, Mt. Morris
- New York State Department of Health, Albany
North Carolina
- The Public Health Authority of Cabarrus County, Inc., d/b/a Cabarrus Health Alliance, Kannapolis

Ohio
- Columbus Public Health, Columbus
- Delaware General Health District, Delaware
- Licking County Health Department, Newark
- Mahoning County District Board of Health, Youngstown
- Summit County Combined General Health District, Stow

Oklahoma
- Comanche County Health Department, Lawton
- Oklahoma City-County Health Department, Oklahoma City
- Oklahoma State Department of Health, Oklahoma City
- Tulsa Health Department, Tulsa

Oregon
- Clackamas County Public Health, Oregon City
- Crook County Health Department, Prineville
- Deschutes County Health Services, Bend
- Marion County Health Department, Salem

Pennsylvania
- Erie County Department of Health, Erie

Texas
- Houston Department of Health and Human Services, Houston

Utah
- Salt Lake County Health Department, Salt Lake City
- Tooele County Health Department, Tooele
Vermont
- Vermont Department of Health, Burlington

Virginia
- Loudoun Health Department, Leesburg

Washington
- Spokane Regional Health District, Spokane
- Washington State Department of Health, Olympia

Wisconsin
- Kenosha County Department of Health, Kenosha
- Oneida County Public Health Department, Rhinelander
- Polk County Health Department, Balsam Lake
- St. Croix County Public Health, New Richmond
- West Allis Health Department, West Allis
- Wood County Health Department, Wisconsin Rapids
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Books and Book Chapters


Communications and Promotions

www.phaboard.org. Website with information about public health accreditation, including the accreditation process, an education center, research and evaluation, fact sheets, and more. The website includes online training modules to assist applicants and site visitors, webinars, accreditation materials (on getting started, documentation preparation, and e-PHAB guidance) and more. Alexandria, VA: PHAB.

www.phaboard.org/news-room/phabnewsletters. E-newsletter Public Health Accreditation Board. Published several times a year, starting in 2009.

Toolkits


