

EXPLORING ACCREDITATION

Final Recommendations for a

VOLUNTARY NATIONAL ACCREDITATION PROGRAM

for



FULL REPORT
WINTER 2006-2007

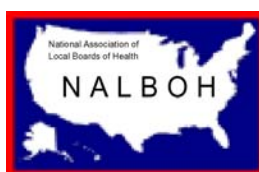
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The time and effort contributed by the Planning Committee has been instrumental
to this process, and their support is greatly appreciated.

*This project was made possible with funding from
the Centers for Disease Control and Prevention (U50/CCU313903-8-1)
and the Robert Wood Johnson Foundation Grant # 053182.*

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ACKNOWLEDGEMENTS

The Planning Committee for the *Exploring Accreditation* project would like to acknowledge the dedication and hard work of those involved with this project, and to express our gratitude for their time and effort throughout the past year. Without the commitment and expertise of each of these individuals, the level of success this project has achieved could not have been reached.

The members of the Steering Committee and Workgroups served as the backbone of this project. We extend our thanks to you. As representatives of their respective sectors in public health, Steering Committee members offered their experience, insight, and time to 'leave no stone unturned' as they proposed the framework for a national accreditation program for state and local health departments. Also instrumental in this effort, were members of the *Exploring Accreditation* Workgroups, whose thoughtfully prepared recommendations facilitated the careful deliberations of the Steering Committee and informed the process at every turn.

We would like to thank the following individuals for their valuable contributions to this project. Michael Hamm of Michael Hamm and Associates lent invaluable expertise and guidance in shaping all of the program recommendations. Chuck Alexander and Francie de Peyster of Burness Communications facilitated project communications and helped keep the field informed and engaged throughout the duration of the project. Shelly Kessler and Jared Raynor of the TCC Group assisted in developing program evaluation principles and also in evaluating project activities.

The participants of the Robert Wood Johnson Foundation Multi-State Learning Collaborative (MLC) contributed substantially to the exploration of accreditation. Representatives of the MLC shared state-level program experiences throughout the duration of the project, both through formal presentations as well as through timely responses to several inquiries. This information provided valuable insights into the design of the model and helped in the consideration of important aspects of program implementation.

The framework for the national accreditation program for state and local health departments was informed by a variety of perspectives, many of which represent the constituencies to be accredited and include not only those mentioned here, but also those who provided feedback during the public comment period. We would like to thank those individuals, whose insight informed the discussions and, ultimately, the final recommendations of the Steering Committee.

We would also like to thank the *Exploring Accreditation* staff, without whom the success of this project could not have been realized. Their time, effort and dedication has been essential to this project in so many ways. Special thanks to the following staff from the Association of State and Territorial Health Officials: Lindsey Caldwell, Jacalyn Carden, Sterling Elliott, Jennifer Jimenez, Pat Nolan (consultant), Adam Reichardt and Mary Shaffran; and from the National Association of County and City Health Officials: Priscilla Barnes, Penney Davis, Grace Gorenflo, Carolyn Leep, Jocelyn Ronald and Jessica Solomon.

Finally, we would like to give special thanks to the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation (RWJF) for their support of this project, which allowed for this monumental project to be carried out. Specifically, Liza Corso, Dennis Lenaway, Anthony Moulton, and Ed Thompson from CDC and Russell Brewer, Carol Chang, and Pamela Russo from RWJF.



A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

EXECUTIVE SUMMARY

Every day in communities and states across the country, public health departments help millions of people lead healthier lives. The *Exploring Accreditation* project provided an opportunity to consider whether and how a voluntary national accreditation program could lead to further improved health for their constituencies. The *Exploring Accreditation* Steering Committee and its Workgroups developed a draft model for such a program. After receiving extensive and thoughtful comments through presentations, web-based feedback, and formal surveys, the Steering Committee revised the model. The Steering Committee also considered a business case for developing and operating the model. The Steering Committee concluded that it is desirable and feasible to move forward with establishing the recommended model program as it is presented here.

This voluntary national accreditation program should:

- Promote high performance and continuous quality improvement;
- Recognize high performers that meet nationally accepted standards of quality and improvement;
- Illustrate health department accountability to the public and policymakers;
- Increase the visibility and public awareness of governmental public health, leading to greater public trust and increased health department credibility, and ultimately a stronger constituency for public health funding and infrastructure; and
- Clarify the public's expectations of state and local health departments.

The following is a brief summary of the recommendations.

Governance

A new non-profit organization should be formed by the Planning Committee organizations to oversee the voluntary accreditation of state, territorial, tribal and local governmental public health departments. The Planning Committee should appoint the initial Governing Board of the new organization. Under its Governing Board, the organization would direct the establishment of accreditation standards; develop and manage the

accreditation process; and determine whether applicant health departments meet accreditation standards. The organization would maintain the needed administrative and fiscal capacity and would evaluate the effectiveness of the program and its impact on health departments' performance. The Governing Board and the organization would advocate for available training and technical assistance for public health departments seeking to meet the standards and to develop a culture of continuous quality improvement.

Eligible Applicants

Any governmental entity with primary legal responsibility for public health at the local, state, territorial, or tribal levels would be eligible for accreditation. Eligibility to apply for accreditation would be determined in a flexible manner, given the variety of jurisdictions and governmental organizations responsible for public health.

Principles to Guide Standards Development

Standards should be developed to promote the pursuit of excellence among public health departments, continuous quality improvement, and accountability for the public's health. The process for establishing standards should consider performance improvement experience among state and local public health departments.

The Steering Committee created 11 domains for which state, territorial, tribal and local health departments should be held accountable. Standards should be established for each domain. Measures of compliance may differ but standards should be complementary and mutually reinforcing to promote the shared accountability of public health departments at all levels of government.

Conformity Assessment Process

Health departments seeking accreditation would undergo an assessment process. It should include a review to determine readiness, a self-assessment, and a site visit, resulting in a recommendation on accreditation status. The final decision on accreditation would be made by the Governing Board. A public health department would be fully accredited, conditionally accredited, or not accredited. An appeals process would be established to resolve disputes.

Financing

The new organization will need initial start-up funding from interested grant-makers, government agencies, and organizations of state and local health departments, some of which may be in-kind support. Subsidies for initial operations will be required, but this phase should be funded in part by applicant fees and other revenues. It is important to attract the full spectrum of local and state public health departments to the accreditation program, and applicant fees should not be excessive or pose a barrier to participation. As the new organization approaches self-sufficiency, subsidies should be directed more toward applicant fees and costs in order to encourage broader participation.

Incentives

Incentives should be uniformly positive, supporting public health departments in seeking accreditation and achieving high standards. Incentives should support the goal of improving and protecting the health of the public by advancing quality and performance of public health departments. Credibility with governing bodies and the public, as well as access to resources for performance improvement should encourage participation by health departments.

Program Evaluation

Evaluation is critical in every stage of the development and implementation of an accreditation program. The accrediting entity should encourage research and evaluation to develop the science base for accreditation and systems change in public health.

Implementation

The details of implementation will be developed by the leaders who take on the challenge of developing the new organization. Implementation will be a multi-year process requiring substantial external support in the development years. Implementation should include rigorous evaluation and process improvements in the accreditation program to make it more successful and cost-effective.

In September 2006, the *Exploring Accreditation* Steering Committee released the document entitled *Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments*. The document describes the concluding recommendations made by the Steering Committee for a national accreditation program.

It was agreed that following the release of the *Final Recommendations*, a comprehensive report would be developed to further explain the conclusions that were made, including the rationale behind the decisions, and the alternatives that were considered. In addition, this report would describe the parties and components that influenced the development of the recommendations including the Steering Committee, the Workgroups, the work of the consultants, a public comment period and report, and a business case.

What follows is the comprehensive report described above. In essence, this document is an expansion of the recommendations released in September 2006. There are new sections on methodology, public comment, and a business case. Following each of the components of the recommended model (e.g. Governance, Eligible Applicants, etc.) is a discussion on the rationale behind it. There are also new appendices to accompany the sections that have been added.

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MESSAGE FROM THE STEERING COMMITTEE

The 2003 Institute of Medicine (IOM) report, *The Future of the Public's Health*, called for the establishment of a national Steering Committee to examine the benefits of accrediting governmental public health departments. Within its *Futures Initiative*, the Centers for Disease Control and Prevention (CDC) identified accreditation as a key strategy for strengthening the public health infrastructure. Several states currently manage statewide accreditation or related initiatives for local health departments. Within this context, in 2004, the Robert Wood Johnson Foundation convened public health stakeholders to determine whether a voluntary national accreditation program for state and local public health departments should be explored further. The consensus was to proceed, and the *Exploring Accreditation* project was launched.

The goal of the *Exploring Accreditation* project was to develop recommendations regarding whether it is feasible and desirable to implement a voluntary national accreditation program or some other method for achieving a systematic approach for public health improvement. In order to achieve the goal, we (the Steering Committee), designed a proposed model program and vetted it through public health officials across the nation. We also considered a business case for the proposed model. *In August 2006, we made changes in the proposed model based on the feedback received and concluded that the revised model is feasible and desirable. We recommend moving forward with implementation.*

We believe the establishment of a voluntary national accreditation program is desirable for many salient reasons. Chief among them is the opportunity to advance the quality, accountability and credibility of governmental public health departments, and to do so in a proactive manner. At least 18 states are involved in performance and capacity assessment and improvement efforts, lending excellent experience to the design of a national program. These experiences illustrate the significant benefits of engaging in accreditation and related efforts — benefits that the national program is designed to achieve. Chief among them are quality and performance improvement, consistency among public health departments, and recognition of excellence. The public comment solicited from public health practitioners

in the field indicated support for a voluntary national program. This program will foster the concept of public health as a system, and promote consistency and high performance nationwide. It also will strengthen the ability to clarify and articulate what public health does, and set reasonable and achievable expectations to this end.

We feel that it is feasible to pursue a voluntary national accreditation program because it is building upon the momentum established by existing state accreditation and performance improvement programs. By taking advantage of knowledge gained from standards development, performance measurement methods, technical assistance projects and other operational components of state-based programs, this program can be flexible, efficient and nimble. Funding is a major factor in starting up and sustaining the new accreditation body through the initial operational phases. We believe the potential for funding a voluntary national accreditation program exists, and we plan to help cultivate that potential. We understand that not all health departments are prepared to become accredited, and this has been factored into the design of a national program (through recommendations to promote the availability of technical assistance and other support for such health departments). We recognize that a national database could facilitate research and enhance the evidence-base regarding best practices and the utility of accreditation as a performance improvement method. Finally, we acknowledge that long-term success will require maintaining the credibility of the accreditation program and continuing interest in the quality of public health departments.

Over 650 public health professionals took the time to participate in public comment activities. This feedback was an invaluable component of the exploration.

A summary of the substantive changes that were made to the proposed model in response to the feedback received include the following:

- Guiding principles for the composition of the Governing Board have been revised to provide more flexibility to the Board of Incorporators by listing general principles as to the composition rather than specific slots (page 18).

- Principles for relationships with state-based accreditation programs have been expanded, such that national accreditation is automatically conferred on health departments accredited by a state-based program that has received formal recognition/approval from the national program (page 19).
- Territorial and tribal public health departments are specifically included in the definition of “eligible applicants” (page 22).
- While applicants are expected to demonstrate compliance with all domains for each program offered, the conformance assessment measurements will be applied on a sampling basis (page 28).

Additional clarifications have been made throughout this document in response to questions and comments received. Public comment yielded both support and concerns about a voluntary national accreditation program. This feedback influenced our final recommendations, and also will inform the program’s structure and operation in an implementation phase. The details regarding public comment can be found starting on page 40.

Following the submission of our recommendations to the Planning Committee, ASTHO, NACCHO and NALBOH each moved to:

- Endorse the recommendations of the *Exploring Accreditation* Steering Committee for a voluntary national accreditation program.
- Lead, in cooperation with appropriate partners, in the development and implementation of such a voluntary national accreditation program that will drive continuous quality improvement.

APHA also included language in their strategic plan to support the national program.

The Planning Committee also shared the recommendations with the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation, both of which funded this effort and have indicated interest in funding and supporting the establishment and operation of the recommended program.

Finally, we would like to thank the Planning Committee and echo their sentiment in thanking the *Exploring Accreditation* Workgroup members, staff, and consultants whose contributions were so vital to this effort. Their collective commitment to this work has been vital to the success of the project (see Appendix A for a full listing).

For up-to-date information on the voluntary national accreditation program for state and local public health departments, visit www.exploringaccreditation.org.

HOW THE MODEL WAS DEVELOPED

In August 2005, the Planning Committee established a 25-member Steering Committee with representatives from public health practice organizations at the local, state and federal levels. The guiding philosophy of the Steering Committee was to leave no stone unturned, considering all possible alternatives related to the issues at hand. Its decisions were informed by the work of four Workgroups in the areas of Governance and Implementation, Finance and Incentives, Research and Evaluation, and Standards Development.

The Workgroups were comprised of public health practitioners from all three levels of government and members of academia. Throughout the duration of the project, the Workgroups developed reports that included consensus recommendations, other alternatives that were considered, and the rationale for each decision. Subject matter experts were also consulted for various issues. Discussion papers with information on accreditation in public health and in other sectors were developed to stimulate the Workgroups’ discussions.

In April 2006, the Steering Committee met to consider all of the information that was gathered in the previous months and to develop a proposed model. The proposed model was distributed for public comment from May through July 2006. During that time, comments were solicited through several mechanisms:

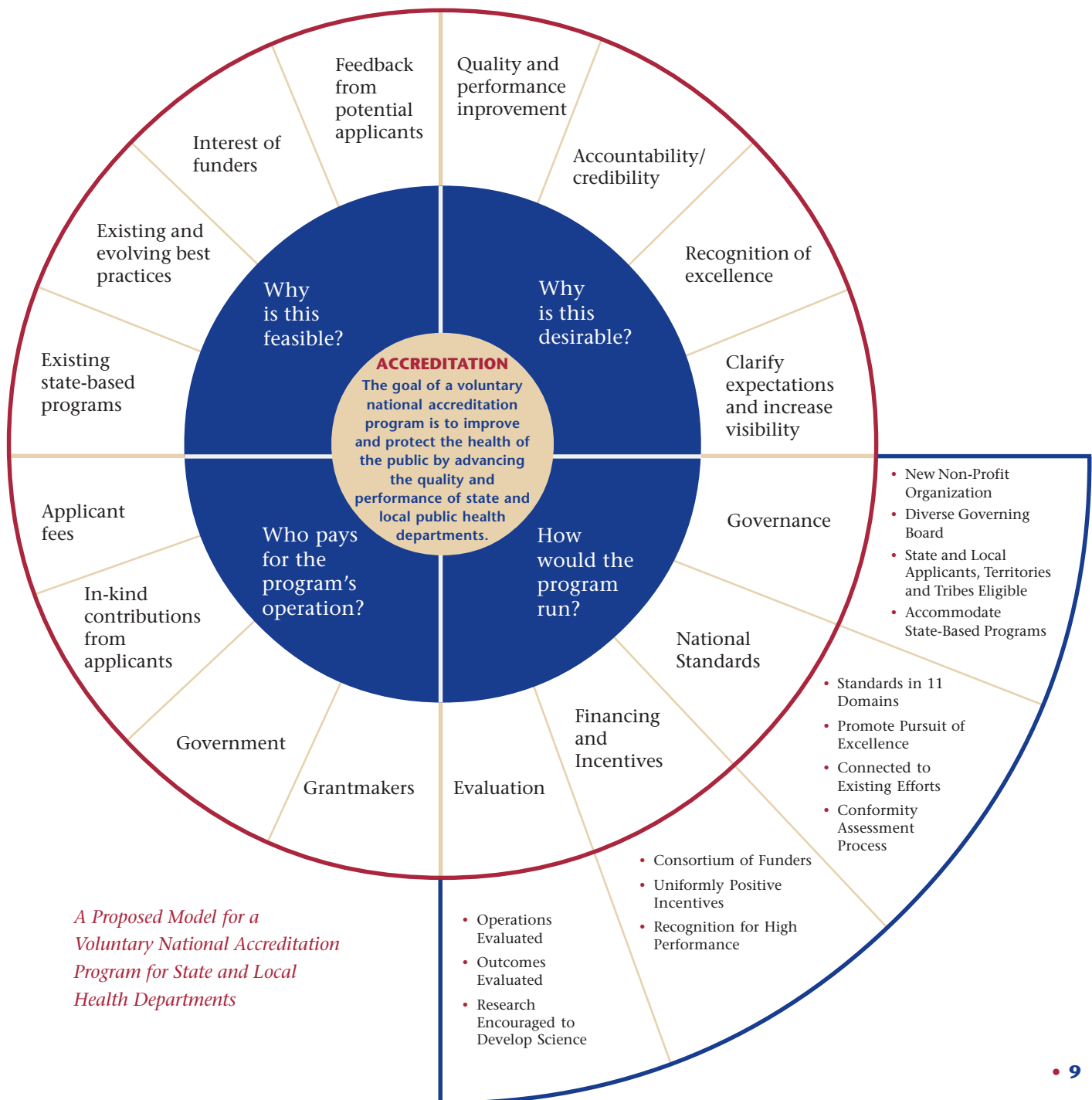
- Public presentations and feedback forms distributed at those events;
- Conference calls;

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- E-mail messages and an online survey on the project Web site;
- A satellite broadcast; and
- An opinion survey sent to state, territorial, and local health officials.

See Appendix A for a full listing of the Steering Committee, Workgroup members, staff, consultants, and funding organization representatives.

Extensive feedback was received, and the Steering Committee met in August 2006 to consider all public comment as well as a business case developed by the Finance and Incentives Workgroup. As a result of the feedback, the model was revised, consensus emerged that the revised model is feasible and desirable to implement, and the Steering Committee recommended that a voluntary national accreditation program be implemented accordingly.





METHODOLOGY

Planning Committee

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 National Association of Local Boards of Health (NALBOH) comprised the Planning Committee for the Exploring Accreditation project. The Planning Committee provided executive oversight to the project and offered representation of their respective memberships. In addition, the Planning Committee established a 25-member Steering Committee in August 2005 to develop recommendations for the voluntary national accreditation program and determine whether they were desirable and feasible to implement.

Steering Committee

The Steering Committee was comprised of public health practitioners from all levels of government. Steering Committee members served as experts and representatives from their respective sectors as they deliberated the desirability and feasibility of a national accreditation program. Their guiding philosophy was to “leave no stone unturned” and consider all possible alternatives related to the issues at hand.

The Steering Committee conducted their deliberations several times in person and by conference call from September 2005 through August 2006. Their discussions were informed by the suggestions developed by the Workgroups and subject matter experts and consultants also provided guidance and information. On occasion, when the Steering Committee felt it was unable to make a decision based on the information provided, the Workgroups were asked to revisit some of their recommendations, explore additional issues, and/or gather more information.

In April 2006, the Steering Committee met to consider all of the Workgroup recommendations that had been generated in the previous months and, based on this information, developed *A Proposed Model for a Voluntary National Accreditation Program for State and Local Public Health Departments*. The proposed model was widely distributed for public comment from May through July 2006. During this time, the Finance and Incentives Workgroup developed a business case to

support the proposed model, and the Research and Evaluation Workgroup completed their recommendations as well.

When the Steering Committee held its final meeting in August 2006, they reviewed the public comment, considered the business case, reviewed the final Research and Evaluation Workgroup recommendations, and revised the proposed model accordingly. *Final Recommendations for Voluntary National Accreditation Program for State and Local Public Health Departments* reflects consensus among the Steering Committee members, and is based on Workgroup recommendations, subject matter expertise, and the public comment that was received.

Workgroups

The Steering Committee’s decisions were informed by the efforts of four Workgroups in the areas of Governance and Implementation, Finance and Incentives, Research and Evaluation, and Standards Development. The Governance and Implementation Workgroup was charged with developing governance recommendations for a voluntary national accreditation program for state and local public health departments. The Finance and Incentives Workgroup was charged with examining the possible ways in which a voluntary national accreditation program could be financed. The Research and Evaluation Workgroup was charged with developing research principles and a framework for the national program. The Standards Development Workgroup was charged with developing principles to guide standards development for the national program.

The Workgroup chairs were Steering Committee members selected by the Planning Committee. The Workgroups were comprised primarily of public health practitioners, and also included members of academia. Workgroup members were nominated and selected by the Steering Committee, and were chosen based on experience and expertise in the four issue areas. The use of Workgroups ensured that a broad perspective of alternatives was considered for each issue area.

Each of the Workgroups met several times from October 2005 through July 2006 to discuss pre-identified issues that were relevant to their group and develop recommendations based on their deliberations (See Appendix B for a list of questions the Workgroups were

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asked to address). Subject matter experts also were consulted, and discussion papers with information on accreditation in public health and in other sectors were developed to inform the Workgroups' discussions. Following each of these meetings, consensus reports were developed that included the Workgroups' recommendations, alternatives that were considered, and the rationale for each decision. These were shared with the Steering Committee (at a January 2006 meeting and via conference calls in between meetings), who, on occasion, asked the Workgroups to revisit some of their recommendations, explore additional issues, and/or gather more information.

The Multi-State Learning Collaborative

In July 2005, the Robert Wood Johnson Foundation provided funding to the National Network of Public Health Institutes and the Public Health Leadership Society to establish the Multi-State Learning Collaborative on Performance and Capacity Assessment or Accreditation of Public Health Departments (MLC). Five states were funded for new work to enhance their existing public health performance and capacity assessment or accreditation programs for local public health departments, and, in one state, also the state public health department. The long term goal of the MLC is to maximize the effectiveness and accountability of governmental public health agencies. The five MLC state programs ranged from mandatory accreditation programs, with or without dedicated funding for applicants, to voluntary participation in performance improvement programs. A common feature among all of them was an established set of standards specific to each state, and a process to assess health department performance against the standards. (It should be noted that 18 states applied to be a part of the MLC, illustrative of the commitment from a wide variety of states interested in accreditation and performance improvement.)

The work of the MLC contributed to the work of the Steering Committee in several ways. Each state was represented on the Steering Committee, and at least one state was represented on each Workgroup, which provided an excellent venue for sharing their experiences and influencing the recommendations. The *Exploring Accreditation* staff visited each MLC state to gather input and wisdom. Additionally, a representative from each state made a presentation to the Steering Committee

and also provided thoughtful feedback on a variety of issues that arose during the year-long exploration, lending their lessons learned and other experiences to the deliberations of the Steering Committee. Finally, a matrix of attributes of each of the MLC states' programs was developed that provided specific details of each program and allowed the Steering Committee to compare and contrast various features (including program goals and objectives; voluntary vs. mandatory nature of the program; development of standards and measures, including what domains were used and the process for updating/revising the standards; processes for scoring and developing criteria; funding sources; costs of the program; participation rates; and program outcomes and impacts). To these ends, the MLC states have served as a learning laboratory, and all the information provided (including site visit reports developed by *Exploring Accreditation* staff) has greatly assisted in informing decisions around the framework for the national program.

The opportunity to learn from operational accreditation and related programs for local health departments and one state health department allowed for more fully informed discussions to take place and for the pros and cons of each program to be reflected in the final recommendations put forth by the Steering Committee.

Communications

From the outset, the *Exploring Accreditation* (EA) project leadership committed to an open process of communication regarding the work of the Steering Committee and its four Workgroups. The project's leaders also sought to provide a robust public input process that would inform, as well as seek comment from, a broad range of interested individuals and organizations regarding the proposed accreditation model. With those objectives in mind, Burness Communications was engaged to oversee communications efforts around the work of the Steering Committee.

The overall goals of the project's communication efforts were to inform key stakeholders, interested organizations, and the public about the project; seek their ideas and learn from them by providing multiple opportunities for feedback during the project and specifically on the proposed model; and finally, to inform interested parties about the project's final recommendations.

These goals were accomplished through:

- Provision of strategic advice on content, methods, and timing of communications;
- Development and promotion of messages in the form of fact sheets, press releases, “Updates” for a stakeholder distribution list; development of PowerPoint presentations on the proposed model and final recommendations; coordination of a CDC Satellite Broadcast; and development of newsletter articles;
- Consultant participation in Steering Committee and Workgroup meetings;
- Editorial support to project staff in the review of project materials; and
- Logistical support for scheduling of the public meetings and member presentations.

Throughout the project, Burness staff worked closely with project staff to discuss, recommend, and implement communication strategies. Near the outset of the project, a two-phase strategy was developed to reach key audiences before and after the Steering Committee’s April 2006 meeting where a draft accreditation model was formulated. Also during the project, guidance was provided on the structuring of an effective town hall presentation for local health officials as well as other options to consider for outreach to various constituencies. Near the end of the project, a communication plan for the Final Recommendations and Full Report was created.

Developing and promoting effective messages for the project’s communications was critical. At the very beginning of the project, a website was created, and a fact sheet and press release were created to inform stakeholders about the project’s activities. A stakeholder distribution list for e-mail communications was also developed and included two “Updates” about the project as well as the press release announcing the Final Recommendations. Another major communications product was the PowerPoint on the proposed model for presentation at the nationwide public meetings. This product was modified over time to reflect updated information including the project’s Final Recommendations.

Another important tool for communicating about the project was the satellite broadcast held at the Centers for Disease Control and Prevention on July 20, 2006, entitled: “Will it Work? Exploring a Voluntary National Accreditation Program for State and Local Health Departments.” The idea of a satellite broadcast evolved from discussions at the Steering Committee’s April 2006 meeting as a means of reaching an extended audience of state and local public health leaders to inform them about the proposed model and seek their input. CDC representatives offered to coordinate the broadcast at CDC headquarters in Atlanta, Georgia, as an adjunct to briefings for CDC leaders on the proposed model. The production was recorded on DVD, distributed to Steering Committee members, and made available to the public for viewing via a link on the project Website.

Although the original project plans anticipated four public comment meetings and one meeting for elected officials, this schedule expanded to more than 25 public meetings or conference calls held nationwide from mid-May through the end of July 2006. This revised strategy reflected the project leaders’ commitment to conduct the broadest possible outreach and the willingness of members to prepare for and give these presentations. The Steering Committee’s deliberations clearly benefited from the feedback obtained from these additional public comment sessions. (For more details on the public comment process see page 40.)

With this communication process, the project ensured that ample and appropriate information conduits were in place for the exchange of information between stakeholders and the Steering Committee, Workgroups and project staff. Regular use of these communications channels contributed to an enhanced final product and improved strategies to share the Final Recommendations.

Accreditation Consultant Expertise

The Planning Committee, Steering Committee, Workgroup members and project staff had strong experience in public health policy and practice; however, with the exception of those from states with accreditation programs, they had limited experience specific to accreditation programs. For this reason, the project hired Michael Hamm, of Michael Hamm and Associates, to lend general expertise on accreditation issues and to specifically advise on the potential fit of an accreditation program in the public health field.

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Accreditation expertise was provided by: educating the Steering Committee, Workgroups, and staff on various aspects of accreditation; conducting market research; and assessing the feasibility of the proposed model and final recommendations.

The project staff and various groups working on this project were informed of the general principles and concepts about accreditation, what it can and cannot achieve, and what accreditation system(s) might work best in a national program designed to serve the needs of state and local public health departments. This was accomplished through preparation of background materials for, and participation in, face-to-face meetings and conference calls with the Steering Committee, Workgroups, and project staff.

Market research regarding the acceptability of a national accreditation program for public health departments was conducted with potential applicants and later summarized. One of the first steps in determining the feasibility of any new accreditation program is the collection of sufficient marketing data to determine the potential interest of various stakeholders in the proposed credentialing program.

Telephone surveys conducted by a neutral third party are one method of collecting market data on the reactions and responses to proposed new credentialing efforts. A series of scripted telephone interviews were conducted with 22 individuals in March 2006.

ASTHO and NACCHO staff contributed to the selection of potential candidates for these interviews. An effort was made to include individuals who were not represented on the Steering Committee or Workgroups of the *Exploring Accreditation* project and who were not involved in the Multi-State Learning Collaborative. Representation included national public health associations, senior officials from state and local health departments, state and local board of health members, and states with existing standards/accreditation programs.

Twenty-two interviews were conducted with:

- Seven national public health association representatives
- A state and a local board of health member
- Nine state health department representatives
- Four local health department representatives

Some of the key questions that emerged included:

- What are the benefits to high performing health departments?
- What are the incentives to attract small health departments?
- Is it really voluntary?
- What resources are available to apply for and maintain accreditation?
- What capacity levels are needed to receive accreditation?
- How does this affect existing state accreditation programs?
- What is the federal government's role?
- What will accreditation cost?
- How will it impact categorical programs?
- How will varying governance structures be accommodated?

The results of the interviews were shared with the Steering Committee when they met in April 2006, and the findings informed the development of the draft recommendations.

The second market survey tool utilized was an online survey of potential applicants. An Internet survey was used to evaluate perceptions about accreditation and the potential market for the proposed model developed by the *Exploring Accreditation* project. Companion online surveys were prepared for both state and local health departments and were administered in late June/early July of 2006. The state and local surveys were similar, but each survey contained some questions specific to their respective audiences. ASTHO and NACCHO staff contributed to the development of the survey instrument, administered the surveys, and contributed to the conclusions expressed in this summary report.

The online surveys were distributed to ASTHO and NACCHO members by their respective staff. Invitations to participate were sent to 57 state and territorial health departments and approximately 2,900 local health departments. A total of 38 complete responses were submitted by state health departments. This response rate was described as "good" for a survey of this audience. Two-hundred-fifteen completed surveys were submitted in response to the invitation by local health

departments. While an 8.6 percent response rate might seem low, staff noted that NACCHO rarely conducts large scale surveys over a short time frame, so the response rate may not be unusually low. Results from this work are discussed in the Public Comment section, starting on page 40.

The Steering Committee and the Workgroups spent a considerable amount of time discussing the results of the market research. The Steering Committee was advised that some opposition is always present in any accreditation opinion study. The challenge for the future Governing Board of the accreditation program is to develop a program that addresses the issues that emerged from the market research (and the public comment period/vetting process – see page 40) to the maximum extent possible.

Finally, Mr. Hamm helped assure that the proposed recommendations were reasonable and feasible for a new national accreditation effort. While some of the recommendations may prove to be controversial, he advised that they are reasonable, defensible and consistent with accreditation programs in other disciplines.

Evaluation

Critical tasks for the *Exploring Accreditation* project were to develop recommendations on evaluation and research related to the national accreditation program. As little research currently exists around the benefits of accreditation for state and local health departments, a national program presents an opportunity for expanding the literature available in this area. Evaluation will be necessary to ensure that the program functions effectively. The evaluation data may also help inform accreditation research and help frame appropriate research questions.

In addition to convening the Research and Evaluation Workgroup (Workgroup), the project contracted with TCC Group (TCC) to support the Workgroup and to evaluate components of the project itself. TCC had several tasks for the project, the first of which was to assist the Research and Evaluation Workgroup with developing their recommendations to the Steering Committee. This included summarizing background information for the Workgroup, developing an evaluation framework, and providing expertise as needed. Additionally, a framework was created to assess the

collaboration between ASTHO and NACCHO for their work as staff of the project.

To fulfill the task of developing background information on accreditation, methods of evaluating accreditation programs were researched by conducting a literature review and interviewing experts in the field. Accreditation programs outside the health field were included in an effort to transfer knowledge and experiences outside of healthcare for use in the project. The review of accreditation in other industries included in-depth investigations of programs viewed as having elements similar to those of a potential public health accreditation program. These included:

- American Association of Museums
- American Forest & Paper Association's Environmental, Health & Safety Principles Program
- American Psychological Association Council on Accreditation
- The American National Standards Institute (ANSI)
- American Zoo and Aquarium Organization
- The Chemical Industry's Responsible Care Program
- Council on Accreditation
- DIN (German Institute for Standardization)
- Green Globe 21
- Fair Trade Labeling Organization
- Ecotel
- International Accreditation Forum Inc
- The International Electrotechnical Commission
- International Organization for Standardization
- ISO Environmental management systems
- Commission on Accreditation for Law Enforcement Agencies

Reviews of these organizations included program aspects and a particular focus on finances. A grid showing the features of other industries' related efforts was developed and the information was presented to the Workgroup through phone calls and e-mail exchanges, and ultimately in-person. Through the process, TCC and the Workgroup thought through important elements of

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evaluation and research and their differences, and developed preliminary thoughts about prioritization of evaluation and research questions.

An evaluation framework and initial outline of potential measures and indicators for consideration was developed. This was a collaborative and iterative process between TCC and the Workgroup. Building on this process, a revised logic model was created. The revisions split the process for creating an accreditation program from the actual implementation of a potential program. Each is reflected in the logic model. In its final recommendations, the Steering Committee refined the strategies and outcomes, making a distinction between organizations pursuing accreditation and the public health field in general. Ultimately, the inputs of an accreditation program were more clearly defined.

Finally, an evaluation tool was developed to assess the collaboration aspect of the project. To assess the effectiveness of the collaboration, a framework with specific indicators was developed for ASTHO and NACCHO and assistance was provided to them with performing the self-assessment using the framework. This approach had several benefits. First, it allowed TCC to highlight best practices identified through past collaboration evaluations, placing them in the context of the ASTHO-NACCHO collaboration. Second, the self-assessment reduced the amount of resources necessary to meet this evaluation need, allowing for more of the budget to go towards the primary goal of helping the Workgroup. Third, the facilitated process enabled ASTHO and NACCHO to learn from their collaboration, enhancing reflection and improving strategies for future collaboration beyond the timeframe of this scope of work.

Public Comment

Throughout the *Exploring Accreditation* project, several mechanisms were used to solicit feedback from the public on the Steering Committee's proposed recommendations. Information on demographics and current participation in performance, certification, or accreditation initiatives was also collected. The data were analyzed and summarized in a way that helped to inform the final recommendations. Below is a brief description of the ways in which information was gathered.

In addition to telephone interviews of 22 individuals in March 2006, an online opinion survey of state and local

health officials, developed by project consultant Michael Hamm, was fielded in June and July 2006 to collect data on their views of accreditation. The survey contained both closed and open-ended questions.

An important finding to note from the surveys was that high percentages of both state health departments (SHDs) and local health departments (LHDs) (47 percent SHDs and 42 percent LHDs) indicated that they are "very likely" to apply for accreditation assuming procedures, fees and timetables are acceptable.

The collective perceived benefits of a proposed accreditation program noted from both the telephone and Internet survey information included the following:

- Credibility;
- Maximizing financial resources (which will be of particular interest to legislators);
- Accountability (also of particular interest to legislators);
- Standardization of practices and developing a national standard;
- Improving public trust in health departments;
- Meeting public expectations; and
- Facilitating access to federal funds.

Collective perceived drawbacks included these issues:

- Variations in health department structure/operation;
- Skepticism about potential standards and the accreditation review process;
- Loss of credibility for non-accredited agencies;
- Challenges of achieving accreditation with limited public health capacity;
- Political issues such as securing approval for accreditation from legislatures;
- Defending departments that are not accredited or their budgets from opponents;
- Potential role of accreditation in influencing how money is spent in public health;
- Concern about potential federal mandates/requirements for accreditation;
- Time and money needed to apply for and achieve accreditation; and
- Public health officials with already complex and extensive work demands.

From the telephone interviews and the Internet survey it was concluded that while accreditation is a concept that is viewed with some skepticism by some of the public health department community, a significant proportion of respondents perceive benefits of this process and are willing to participate in a future program depending upon the final details of the standards, the accreditation process, and the required fees. The highest degrees of skepticism and concerns were expressed in the telephone interviews by the small and rural public health departments, states that include large numbers of these entities, and some national organizations focused on meeting health department needs in these specific communities.

Four additional mechanisms were developed and used by staff to receive public comment. Numerous presentations were made on the proposed recommendations from May through July 2006 (see Appendix D). These presentations were delivered in person, via conference call, and through a satellite broadcast. Speaker and participant feedback forms distributed during the in-person meetings were used to collect comments on the draft recommendations. The *Exploring Accreditation* Web site also provided opportunities for comment. Visitors could access an online survey which asked the same questions as those presented on the participant feedback form. Additionally there was an e-mail address accessible on the Web site that users could utilize to submit feedback or ask questions.

The participant feedback forms and the online survey were identical (see Appendix C). There were three closed-ended questions using a Likert scale, four open-ended questions, a request for demographic information, and a question regarding current participation in performance, certification, or accreditation initiatives. The e-mail responses were analyzed in a manner consistent with the questions posed on the participant feedback forms.

The 540 responses (a combination of participant feedback forms, the online survey, and comments via the e-mail address) were analyzed collectively, with both quantitative and qualitative analyses.

The full analysis of the public comment can be found on page 40. A list of the presentations given during this time can be found in Appendix D.

Business Case

With information from a variety of sources and assistance from consultant Michael Hamm, the Finance and Incentives Workgroup (Workgroup) developed an operational description of a business model that could be used to implement the proposed voluntary national accreditation program. The business model and the budget related to it were refined in the Steering Committee deliberations as decisions were made concerning the final recommendations. The business case as refined is useful in answering the question, "If we move forward with this model, what will it cost?" Varying the options in the business case can help implementers evaluate the changes in cost that will be created by changes in the operational model and to predict their effect on the potential to attract applicants and revenues that will support this business model.

The Workgroup began with an assessment of the need for a voluntary national accreditation program drawn from the Steering Committee work. With the assistance of surveys conducted by Michael Hamm and Associates and using summaries of public input, the Workgroup analyzed the market for accreditation and projected the likely penetration of the market, then examined the competitive environment. The findings from examining other accreditation programs' experiences and public comments were integrated with the model recommended by the Steering Committee to describe the business environment for a voluntary national accreditation program in the next nine years. The Workgroup projected the market for the proposed accreditation program's product, the volume of work in the development and initial operation phases, and the potential revenues generated from services.

To understand the financial feasibility of the proposed business case, the Workgroup reviewed the model and identified operating options compatible with the model. The Workgroup then identified the components of cost for the developmental period (from incorporation through pilot testing of the standards and the conformance process) and the initial operating period (five years of actual operation) of the accreditation

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program and the options which affect the ranges of these costs. Then the Workgroup projected costs of the developmental period and the initial operating period by generating a range of options for key variables and pricing a “preferred set of options” based on the model itself. As described in the finance and incentive sections of this document, preferred options were based on assessments of best outcomes for the program, balancing efficiency and cost control with transparency, full participation by the public health field, and accountability to the public.

A positive business case depends upon demonstrating the potential for the proposed accreditation program to generate revenues to cover its costs within a reasonable developmental and operational period. The Steering Committee identified several potential revenue sources and provided guidance through its deliberations about sources not acceptable within its model. The Workgroup integrated the Steering Committee guidance into the estimates of both work and revenues in the development and operating periods, projecting a range of options.

The Steering Committee reviewed the operational description in the business case and made refinements in their final recommendations. Their deliberations provided opportunity to incorporate key issues that surfaced through the public comment process and to shape the final recommendations while considering costs and operational impacts. These deliberations were particularly important in making the decision about the feasibility of the recommended model for a voluntary national accreditation program.

The business case was then revised to reflect the final recommendations and the final version is included as part of this full report.

Logic Modeling

The Research and Evaluation Workgroup developed a series of logic models to guide thinking about evaluation of on-going work in both the design and implementation of a voluntary national accreditation program for state

and local public health departments. The Workgroup created separate logic models for:

- evaluating the *Exploring Accreditation* project, and
- evaluating the implementation and operation of a national accreditation program.

Taken together, these logic models are intended to provide a framework for evaluation and to promote research on the public health impact of the work.

These logic models facilitate the identification of key evaluation questions for each stage of the project and a developing national program (see Appendix F). The logic models illustrate both intermediate and long term outcomes to encourage research questions that would elucidate the role of accreditation in achieving these outcomes. The Workgroup intended its work as a starting point for developing an evaluation strategy and research agenda.

FINAL RECOMMENDATIONS AND DISCUSSION

This section of the report includes the recommendations as they appear in the *Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments*. Each recommendation section is followed by a discussion that includes the rationale for all decisions made.

GOVERNANCE

A new, not-for-profit entity should be created to oversee the accreditation of state and local governmental public health departments by adopting standards and making final conformance decisions. Having a new, independent entity would promote impartiality and avoid real or perceived conflict of interest should the process be conducted by an existing organization. The Planning Committee should provide an incorporation process (articles of incorporation, bylaws, Governing Board nominations process) that establishes the legitimacy and credibility of the accrediting entity.

Accrediting Entity

The accrediting entity should:

- Be a recognized legal entity and a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code.
- Be separate and independent of the influence of any single organization.
- Provide relevant accreditation services and avoid activities that could conflict with accreditation activity.
- Orient applicants to the application and assessment processes.
- Develop and maintain partnerships.
- Assess conformance.
- Train assessors to assure a consistent and fair process.
- Work with partners to ensure the availability of training and technical assistance.
- Encourage research and evaluation to improve the accreditation program.

Governing Board

This new entity should have a Governing Board that would obtain incorporated status, develop bylaws, and hire staff. The responsibilities of the Governing Board should include, but not be limited to, the following:

- Approving standards.
- Awarding and revoking/suspending status.
- Overseeing the appeals process.
- Ensuring adequate representation of key stakeholder interests.
- Including public representation in all decision making.
- Establishing clear and effective controls against conflict of interest.
- Ensuring ongoing evaluation and continuous quality improvement of the accreditation program.
- Overseeing the development and maintenance of a national database for performance improvement and research purposes.
- Promoting research that would improve the accreditation program.
- Maintaining the administrative and fiscal capabilities to successfully operate a national accreditation effort.
- Working actively with partners to promote their development of positive incentives.
- Working with partners to advocate for and promote training and technical assistance and assure that they are accessible and available to applicants.

The Planning Committee should appoint the Governing Board. Membership of the Governing Board should include both organizational representatives and individuals with relevant experience and expertise. While specific slots are not being recommended, the following principles should be applied in determining the composition:

- Members with recent experience in state or local public health should comprise the majority.
- Members should include those with recent experience on public health governing boards.

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- Diversity of ethnicity, experience, and geographic location is important.
- Terms and term limits should be specified.
- Members should include academics, state and local elected officials, health care providers, representatives from federal agencies, and others with a public health background.
- One or more public members should be appointed.
- Members should include representatives of the founding organizations and other key public health organizations.

Relationships with State-Based Accreditation and Performance Improvement Programs

The goal of the voluntary national accreditation program is to establish quality and consistency that is recognized at federal, state, and local levels. Existing state-based accreditation and performance improvement programs are providing a laboratory for a national program and national standards. It is important that state and national programs continue to learn from and maintain good relationships with each other.

A national program should complement state-based efforts to establish performance standards for public health departments. This may be accomplished by a recognition/approval process through which state accreditation programs could demonstrate conformity with national accreditation standards and processes. Such a process should not preclude states from having additional requirements over and above those in the national program. If a state accreditation program is not so recognized, it may seek to act as an agent.

Agents/Contractors

The accrediting entity may use agents (such as state based accreditation programs and public health institutes) to provide training, preparatory services, site visits, and other services. The accrediting entity is responsible for developing policies and procedures regarding relationships with agents. The agent must demonstrate to the satisfaction of the Governing Board that its services are consistent with those of the accrediting entity. When agents are used, the Governing Board still makes the final accreditation determination.

Confidentiality

Confidentiality of information is important to achieving the quality improvement and continuous performance improvement goals of the voluntary national accreditation program. The accrediting entity may publicize the accreditation status of applicants, but should hold all background information from the process as confidential except as required by law.

GOVERNANCE DISCUSSION

The Governance and Implementation Workgroup was tasked with developing governance recommendations for a voluntary national accreditation program for state and local public health departments to be considered by the *Exploring Accreditation* Steering Committee.

For several of the governance recommendations, the Steering Committee and the Governance and Implementation Workgroup found value in the guidelines for an accreditation system outlined by the International Organization for Standardization (ISO). ISO has set standards and guidelines for many accrediting bodies. These international standards specify the general requirements for accrediting bodies and as such may represent the fundamentals for a model system. Further, these guidelines could eventually serve as a frame of reference for best practices in accreditation.

A single national body that sets standards and assesses conformance was determined to be the best governance plan to promote an understanding and appreciation of the work done by state and local public health departments. A national body provides the public health field an enhanced ability to identify what public health is, what public health departments do, and how they function to achieve improvements in the public's health. By establishing conformance with a common set of standards, this model provides external validation of services offered, capacities required, and quality of performance. External validation by a single body is a means of improving public health services throughout the United States more efficiently than independent, non-linked systems at state and local levels.

It was recommended that the national entity be a new organization. A new entity that is not affiliated with an existing public health organization will safeguard the objectivity and impartiality of its activities. Further, it will



assure that no single party or party interest predominates. A new entity could also eliminate the perception of a conflict of interest, assure that states with existing accreditation/accreditation-like programs can participate, and protect conformity assessment information and confidentiality. Using existing organizations was considered. The Workgroup acknowledged that this option could be less costly by offsetting operating expenses. It could also save time for getting the national program started if a new organization did not need to be created or an existing organization could be used to handle administrative functions while a new entity was waiting to be established. In the end, the Workgroup felt that assuring impartiality was important and therefore agreed that it would be most appropriate for the governing entity to be supported by a new organization. However, it was recognized that the new organization may need some assistance with administrative functions during its startup phase, and for this purpose an existing organization could be used.

To further ensure that there is no perceived conflict of interest, it was determined that the accrediting entity should not be the direct provider of technical assistance to applicants, nor should they be directly responsible for carrying out research and external evaluation. The Steering Committee recognized that it would not be appropriate for the accrediting entity to assist health departments with meeting the standards. Yet, to ensure that applicant health departments receive the support needed to effectively achieve the program standards, the Steering Committee felt that it was the responsibility of the accrediting entity to ensure that technical assistance resources were available from the outset. For similar reasons, it was agreed that the accrediting entity should not be the organization responsible for performing research on its own program. The Steering Committee agreed that while the entity should regularly assess its own performance, it should encourage others outside of the organization to analyze the strengths and weaknesses of the accreditation program. As little research exists in this area, this is an important opportunity to build the evidence base for quality and performance improvement programs by collecting and sharing data. The accrediting entity will be responsible for ensuring that all of its operations and its performance are evaluated on an ongoing basis. The Steering Committee recommended

that funding for evaluating the accrediting program be included in the business plan. This would include funds for the accrediting entity to develop an evaluation of the entity's effectiveness, the accreditation process, customer satisfaction, and performance improvement of the health department. Applicants who go through the process of accreditation would be asked to participate in the evaluation. The results would help to improve the program as it is updated periodically.

The Planning Committee of the *Exploring Accreditation* project will be responsible for the initial incorporation of the national program. They have led the *Exploring Accreditation* project since the inception. As such, they are familiar with the thought processes behind the recommendations and therefore are best able to ensure that these are carried out efficiently in the development of the new program. The Planning Committee organizations also represent the future applicants and key stakeholders for the national accreditation program and are therefore the logical organizations that would be important to getting buy-in to the program. Incorporation responsibilities will include, but not be limited to, establishing the new organization (Governing Board, bylaws and articles of incorporation, business plan, staff), and beginning the groundwork of the program (developing standards and incentives).

Since the Planning Committee will be the initial incorporators of the new organization, the Steering Committee felt that it made sense for them to appoint the first Governing Board. Several suggestions for board composition were explored. For the accreditation program to be sustainable, the board needs to assure the maintenance of effective and efficient relationships among federal, state, and local levels. The Steering Committee felt that both public health organization participation and the inclusion of individuals with specific expertise were important. Having representatives from well-respected organizations on the board will contribute to the credibility of the program. In order to counterbalance the interests of the organizations represented on the board, and to ensure expertise in specific areas is included, it was agreed that individual expert representation would also be needed on the board.

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In the proposed model recommendations, specific characteristics of membership on the board were identified. However, many concerns were raised during the public comment period about this recommendation. One theme was the perception of imbalance among representatives from certain domains. Another concern centered on what the most appropriate number of representatives for the Governing Board should be. For the Final Recommendations, the Steering Committee decided not to recommend specific slots for the board, and instead they have recommended principles to guide the Planning Committee in their selection of board members. The Steering Committee felt strongly that the majority of the members on the board should have recent state or local governmental public health experience. Recent experience was seen as important because health departments are constantly changing and this representation would ensure that the views of applicants are well represented while avoiding a direct conflict of interest. Boards of health representatives were also seen as key members since many state and local health departments must report to or seek the guidance of their board. Additional recommendations for board member representation include academics, state and local elected officials, health care providers, federal agency staff, and members of the founding organizations of the national accreditation program.

In addition to the board, the Steering Committee has suggested that ad hoc committees may need to be periodically developed beyond the Governing Board to deliberate certain issues (i.e., the assessment process, standards, and nominations for the Governing Board). These committees would help reduce the burden on the Governing Board as well as provide additional expertise on specific issues.

The Steering Committee recognized the importance of acknowledging those states with existing accreditation or related programs. During the public comment period several states raised questions about how their existing or emerging programs would tie into the national one. It was agreed that states should receive some sort of recognition or approval if they demonstrate conformity with the national accreditation program. This should not imply that any existing state program would be grandfathered into the national program. Whatever the requirements are of their own programs, states would be expected to meet those of the national program. This

would avoid duplication of effort on the states' part, and recognizes that states cannot forgo their current programs given that they may have specific legal requirements they need to meet.

The recommendations for agents/contractors to the national program are in line with those of ISO. It was agreed that some entity or entities within states should be allowed to act as agents or contractors under the national program. Agents could include the state health departments or the public health institutes that are currently responsible for assessing conformance in their state. Using agents would lessen the burden on the national accrediting entity by having fewer assessments to conduct. The use of state agents/contractors, however, does not alter the expectation that the national Governing Board will make the final accreditation determination.

During the public comment period, the most cited benefit to a national accreditation program was recognition of health departments. While accredited agencies would want their status publicly recognized, the Steering Committee has recommended that all background information collected during the conformity assessment process be kept confidential. The one exception to this recommendation would be if a legal request were made to review this information, e.g., if a court requests the information because a health department is being sued. Assuring applicants' confidentiality is critical in the accreditation process. This assurance should be built into the development of the governance structure. Not only would this apply to the accrediting entity, but all agents, vendors and contractors would also be expected to protect access to specific accreditation data.



ELIGIBLE APPLICANTS

The governmental entity that has the primary statutory or legal responsibility for public health in a state, a territory, a tribe or at the local level is eligible for accreditation. To be eligible, such entities must operate in a manner consistent with applicable federal, state, territorial, tribal, and local statutes. The determination of eligibility to apply for accreditation should be flexible, recognizing the variety of jurisdictions with local public health departments and the variety of state, territorial, tribal and local governmental agencies that may carry the primary responsibility for public health.

State and Territorial Health Department

The governmental body recognized in the state's or territory's constitution, statutes, or regulations or established by Executive Order, which has primary statutory authority to promote and protect the public's health and prevent disease in humans, is eligible to apply. Umbrella organizations and collaborations among state or territorial agencies may apply for accreditation if the primary entity is a part of the organization or collaboration. Where the state or territorial health department operates local and/or regional health departments, a single applicant or a number of individual applicants may choose to apply. Compliance with local-level standards must be demonstrated for each local/regional unit.

Local Health Department

The governmental body serving a jurisdiction or group of jurisdictions geographically smaller than a state, which is recognized in the state's constitution, statute, or regulations or established by local ordinance or through formal local cooperative agreement or mutual aid, and which has primary statutory authority to promote and protect the public's health and prevent disease in humans, is eligible to apply. The entity may be a locally governed health department, a local entity of a centralized state health department, or a regional or district health department. An entity that meets this definition may apply jointly with other local-level eligible entities for accreditation status if some essential services are provided by sharing resources and the manner in which this occurs is clearly demonstrated.

Tribal Health Department

The governmental health department serving a recognized tribe that has primary statutory authority to promote and protect the public's health and prevent disease in humans is eligible to apply. Applications should include an opportunity to describe situations where statutes or other legal mechanisms delegate authority for governmental public health functions to an agency other than the applicant health department. The applicant health department should demonstrate collaboration with other agencies with respect to those functions or, in some instances, may request exemptions from those standards that are being met in a different governmental agency. The designation of accreditation should note any exemptions provided. Additionally, the applicant health department may include another entity with statutory authority to perform some public health functions in its application, and the other entity may be accredited or recognized solely for the standards that it meets.

Applications should include an opportunity to describe situations where statutes or other legal mechanisms delegate authority for governmental public health functions to an agency other than the applicant health department. The applicant health department should demonstrate collaboration with other agencies with respect to those functions or, in some instances, may request exemptions from those standards that are being met in a different governmental agency. The designation of accreditation should note any exemptions provided.

Additionally, the applicant health department may include another entity with statutory authority to perform some public health functions in its application, and the other entity may be accredited or recognized solely for the standards that it meets.

The purpose of the voluntary accreditation program is to improve the quality and performance of public health departments without regard to their structure. Health departments may wish to explore cooperative arrangements to help ensure compliance with accreditation standards.

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ELIGIBLE APPLICANTS DISCUSSION

The definition of eligible applicants is intended to be as inclusive as possible, understanding that health departments vary widely. The Steering Committee has identified eligibility criteria for state and territorial health departments, local health departments, and tribal health departments. The governmental entity that has the primary statutory or legal responsibility for public health in a state, a territory, a tribe or at the local level is eligible for accreditation. This description captures the notions of entities being governmental in nature, having statutory responsibility, and providing the essential services (as opposed to a list of programs), and it accommodates the many types of governance structures that exist. It also recognizes the fact that some health departments ensure the provision of some, but perhaps not all, essential services. The process of identifying the eligible entities required significant discussion given the variation in how state and local health departments are governed (e.g., in some states the local health departments operate as separate entities from the state health department, and in other states they operate as one unit).

While it may not have been explicitly stated in the draft recommendations, the intent of the Steering Committee is for the accreditation program to be open to tribal health department participation. As a result of feedback received during the public comment period on this issue, the Steering Committee agreed that the final recommendations should state clearly that tribal health departments are also eligible entities for the national program.

The Steering Committee was also reminded during the public comment period that it is not uncommon for public health services to be provided by non-governmental members of the public health system. As such, they have recommended that applicant health departments be allowed to demonstrate these situations during the conformity assessment process in order to help them to meet the required standards.

In addition, the Steering Committee recommended that joint applications for local health departments be allowed. It is expected that being able to apply jointly would motivate local health departments with fewer resources to consider ways in which their existing assets

might be shared more effectively, with the end result of achieving accreditation standards and better serving the population. This notion of joint applications is a prime example of demonstrating quality improvement. By applying jointly, local health departments can show that they are able to combine resources rather than duplicate them, in order to provide services to the community.

Some states delegate authority for public health functions to governmental entities other than the health department. This can occur at the state and/or local level, and in these instances the health department cannot be held accountable for functions performed by other governmental entities. Ideally, these other governmental entities would have their functions assessed to ensure that they are providing quality services. If the other governmental entity chose to apply, they would be accredited only for those service(s) provided. While the Steering Committee does recommend that applicant health departments make an attempt to work with the other governmental entities in the accreditation process, they do understand that this could be difficult if the other agency is not willing to participate. For this reason, the Steering Committee has recommended that health departments be able to claim exemption for the functions for which they are not responsible.

PRINCIPLES TO GUIDE STANDARDS DEVELOPMENT

A voluntary national accreditation program is a tool to advance the pursuit of excellence, continuous quality improvement, and accountability for the public's health. Standards should be developed in a way that promotes these attributes.

Standards should address process, capacity, and indicators of outcomes. As the evidence is established, outcome standards that address improved health indicators could be added; in the shorter term, outcomes should address achievements such as establishing programs and implementing new policy. Standards should focus on outcomes that can reasonably be influenced by health departments, understanding that public health is inextricably linked to many systems and occurrences that affect health status.

NACCHO's Operational Definition of a Functional Local Health Department should serve as the foundation of standards (and associated measures) for local health departments. ASTHO is undertaking a review of state public health services that may inform the standards development process for state health departments. Existing performance standards for state and local health departments should also be considered.

National Public Health Performance Standards Program (NPHPSP) model standards and measures could be used in developing health department standards, recognizing that NPHPSP standards have been developed to assess systems, not departments.

State, territorial, and local health departments should be held accountable to the 11 domains listed on the following page, with standards under each domain that are specific to their respective responsibilities. Additionally, the standards should be complementary and mutually reinforcing to promote the shared accountability between state/territorial and local health departments. The Governing Board will determine which set of standards is applicable to tribal health entities.

One or more standards should be associated with each domain and at least one criterion should be used to operationalize each standard. Measures, or the objective means to determine whether, and the extent to which

each criterion is met would be established for each criterion. Measures allow an observer to characterize the level of quality achieved for each criterion.

Collectively, standards and their associated criteria define the capacity expected of an accredited department. These criteria should be reflected in the day-to-day work of individual health department programs but are not meant to be illustrated only through programs since the capacity of a local health department to meet the needs of its community is represented by its ability to address new or emerging situations as well as those associated with day-to-day operations.

Program specific standards and criteria exist separately and are outside the scope of the voluntary national accreditation process since programming varies from state to state and locality to locality.

Standards should be designed to assure public health protection while improving the public's health. All applicant health departments should be held to the same standards. However, different measurements may be used to recognize the variety of ways in which the standards are met by health departments with different capacities, governance structures, statutory authorities, other quality improvement processes and health status of the population served. The program should promote continuous quality improvement, and over time, the level of acceptable performance should be increased as the norm of performance rises.

Selected principles espoused by the American National Standards Institute (ANSI) should be applied to developing and updating standards:

- Consensus on a proposed standard by a group or "consensus body" that includes subject matter experts and representatives from materially affected and interested parties.
- Broad-based public review and comment on draft standards.
- Consideration of and response to comments submitted by voting members of the relevant consensus body and by public review commenters.
- Incorporation of approved changes into a draft standard.

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Standards should reflect input from all levels of government. Further, they should be updated and refined on a regular basis to reflect the best available evidence.

Standards need to be sensitive to laws governing state, territorial, tribal and local public health entities, and applicants should be permitted to request a waiver or modification of an accreditation standard if compliance could put them at risk of violating state, territorial, tribal or local law.

In order to promote a common agenda and linkages among all levels of government, those involved in developing and updating standards and measures in a voluntary national accreditation program should work closely with entities supporting other national goals, standards and measures for public health.

Careful consideration should be given to how standards for health departments can be applied in an efficient, non-duplicative and non-conflicting manner, and the Governing Board should consider ways to use alternative measures of meeting standards, e.g., when a standard essentially has been demonstrated to have been met through reporting requirements for contracts, or state or federal grants.

STANDARDS DEVELOPMENT DISCUSSION

Throughout its deliberations, the Steering Committee emphasized that the national program should promote quality and performance improvement, and stressed the need for standards to reflect this emphasis. This was an overarching theme for the Steering Committee and Standards Development Workgroup's discussions. In addition, the Workgroup provided additional detail in their recommendations that went beyond the level of detail sought by the Steering Committee. These additional details may be useful during the program implementation and will be available to the accrediting entity.

The Steering Committee made a very deliberate decision at the outset of its work not to recommend particular standards for the program, but rather principles to guide the development of standards. They recognized up front the importance of engaging the practice community and subject matter experts as standards are developed, and felt it would be too ambitious, as well as out of sequence, to initiate such an effort as part of this exploration. The American National Standards Institute principles referenced in the final recommendations clearly speak to the inclusive developmental process that the Steering Committee recommends as a national program is implemented. It was agreed that a combination of capacity, process and outcome standards is desirable as the basis for an accreditation program because it is likely to be the most effective way of addressing improvement in governmental public health agencies.

Health outcome standards were viewed as the most desirable with respect to demonstrating the impact of public health interventions – particularly to governing boards, elected officials, and the general public. Although a robust evidence base to support such standards does not exist, the Steering Committee also

*Domains**

1. Monitor health status and understand health issues.
2. Protect people from health problems and health hazards.
3. Give people information they need to make healthy choices.
4. Engage the community to identify and solve health problems.
5. Develop public health policies and plans.
6. Enforce public health laws and regulations.
7. Help people receive health services.
8. Maintain a competent public health workforce.
9. Use continuous quality improvement tools to evaluate and improve the quality of programs and interventions.
10. Contribute to and apply the evidence base of public health.
11. Govern and manage health department resources (including financial and human resources, facilities, and information systems).

* *See Appendix E (page 64) for examples of standards and measures.*

did not want the field to shy away completely from health outcomes standards. It is not unusual for the public health field to limit the use of health outcome standards since there are many factors beyond the influence of governmental public health departments that influence health status, thus making it difficult to link public health interventions to improved health status. The conclusion was that health outcome standards should be added as the evidence base expands to support them, and in the interim, other indicators of outcome (as described in the final recommendations) could be effectively incorporated.

Process measures can serve as a good internal management tool, particularly when they are shown to be linked to outcomes. Process measures are also more responsive to change. In addition, the Workgroup recommended that a standard be included regarding the process undertaken by state and local health departments to assess health problems and achieve health-related goals. This type of standard would attend to the desire to address health outcomes as part of the accreditation process.

Additionally, capacity measures are useful to administrators to help define infrastructure needs, defend procurement decisions, and make budget decisions. They also present an opportunity to tie capacity to outcomes, and are also more responsive to change than outcome measures.

By using a combination of standards that measure capacity, process and outcomes, the strengths found in one set of measures could help offset deficiencies in others. Furthermore, this comprehensive approach would cover many bases with respect to what an accreditation system may seek to accomplish and the target audiences for accreditation results. This approach will also help demonstrate the connections between capacity, process and outcomes – all of which must be considered to improve agency performance and ultimately public health.

The Steering Committee views existing standards as the cornerstone to developing standards in the national program. Several sources in particular were identified that should receive special consideration in order to avoid “re-inventing the wheel.” As discussed in the

context of recognizing existing state-based accreditation and related programs, various states offer a learning laboratory with respect to the standards they have in use for performance and quality improvement. In addition, NACCHO’s Operational Definition was recognized as a framework for local health department standards, as it was developed through an extensive vetting process and reflects perspectives from public health professionals at all three levels of government, as well as local and state elected officials.

The merits of the National Public Health Performance Standards Program (NPHPSP) model standards and measures also were recognized as a source for health department standards. It is important to clearly recognize that NPHPSP standards have been developed to assess public health systems, not individual public health departments, so any standards used would need to be adapted in order to accommodate this difference. Moreover, the Workgroup noted that assessment of the public health system using the NPHPSP instruments could be a recommended “self study” in preparing for or maintaining accreditation. Such attention to the public health system, in a manner that complements health department-specific standards, could serve to emphasize the important role of external relationships and document the role that health departments play in creating such a system.

The Steering Committee identified 11 domains, or categories, of standards that should be included in a national program. They are intentionally worded to be understood by all intended audiences, including future applicants, governing bodies, policymakers, funders and the public. Using the same set of domains, but different standards, for state/territorial and local health departments builds into the system a degree of synergy between these two levels of government, while recognizing that state responsibilities are different from local ones. Such an approach also creates incentives for better working relationships. Until specific standards and measures have been identified, it will be difficult to determine which set applies to tribal health entities, and therefore this decision will be made by the Governing Board.

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The level of performance that the standards are intended to describe generated a great deal of discussion, during which the following themes emerged:

- If health departments are essentially receiving a “seal of approval” through accreditation, the public will expect that a gold standard of sorts has been achieved.
- Continuous quality improvement has been hailed as the cornerstone of the accreditation program, and therefore it should be expected that health departments will “reach and stretch” as they work toward achieving higher levels of performance.
- If the standards are set too low, and most health departments easily achieve accreditation status, then this effort has missed a critical opportunity to serve as a catalyst in strengthening the nation’s public health infrastructure.

Within this context, the Steering Committee agreed that a moderate level of performance should be sought, with the understanding that continuous quality improvement aspects would be built in. However, great caution needs to be exercised in selecting terms used to describe this level. In lieu of stating “moderate” (which was viewed as having the potential to suggest a substandard level of performance), the language chosen reflects the philosophy in the Operational Definition, i.e., everyone should reasonably expect that their health department is performing in a manner that assures public health protection while improving the public’s health. This mid-level does not describe a “gold standard,” but rather strikes an important balance between being realistic about what can be achieved and leaving room for health departments to improve. Furthermore, as the number of accredited health departments grows, and as the norm of expected performance rises, standards and measures will need to be updated and revised accordingly.

Another important theme emerged both in the Steering Committee’s initial deliberations and the public comment period around the need to make sure that the standards are relevant and applicable to health departments of all sizes. The national system needs to be attractive to more robust health departments in order to be credible, yet it must not be out of reach of health departments with fewer resources or those constrained by state statutes. However, the desire to include health

departments with fewer resources should not compromise the level of standards. This issue was addressed by agreeing that while all health departments should be held to the same standards, different measurements may be used to recognize the variety of ways in which the standards are met by health departments with different capacities, governance structures, etc. For example, every community needs to be served by epidemiological expertise. Larger health departments may need to have an epidemiologist on staff, while smaller health departments may need to demonstrate that they have ready access to an epidemiologist if needed, e.g., through an epidemiologist who is employed on a regional basis, through a mutual aid agreement with another local health department, or from the state health department.

The Workgroup provided more detailed recommendations regarding how frequently standards should be updated, in order to make sure that the standards in play during any accreditation cycle are as relevant as possible for the entity being accredited. Therefore, the duration of accreditation status and the length of time that it takes to become accredited should be factored into the interval for updating standards. The Workgroup recommended that once an application process has begun, the standards used, from initial application through any conditional accreditation period (should one be used), should remain the same. It also was recommended that standards should be updated more frequently in the initial stages of a national program in order to make corrections, reassess how well they are working, and reestablish the process as needed to maximize the effectiveness of the standards.

Finally, another key issue discussed by the Steering Committee and raised during the public comment period was the need to develop standards in a manner that avoids duplication of effort to the extent possible. A potential barrier to accreditation is the perception that the conformity process will entail additional paperwork, and the Governing Board should consider ways to promote accredited status as a proxy for other accountability measures, e.g., accreditation status could be used in lieu of reporting requirements for grantors or contractors. This notion is consistent with the potential incentive of streamlining reporting requirements for grant funds.

CONFORMITY ASSESSMENT PROCESS

The conformity assessment process should begin with the health department undertaking training and a readiness review. If the health department determines that it is ready, it secures application materials and completes a self assessment. The application should include confirmation that the applicant’s elected official/ governing body supports the application. The applicant submits their completed self assessment to the accreditation staff who review it. When it is accepted as complete, a site visit is arranged.

Applicants are expected to be in compliance with all domains for each program offered. Performance assessment measurement will be applied on a sampling basis to determine compliance.

A team conducts the site visit, writes a report, and makes a recommendation based on the findings and the self assessment. There will be an opportunity for the applicant to address any deficiencies that are noted. The site visit team includes peers without conflicts of interest and other subject matter experts/consultants, all of whom meet training and performance requirements of the accrediting entity.

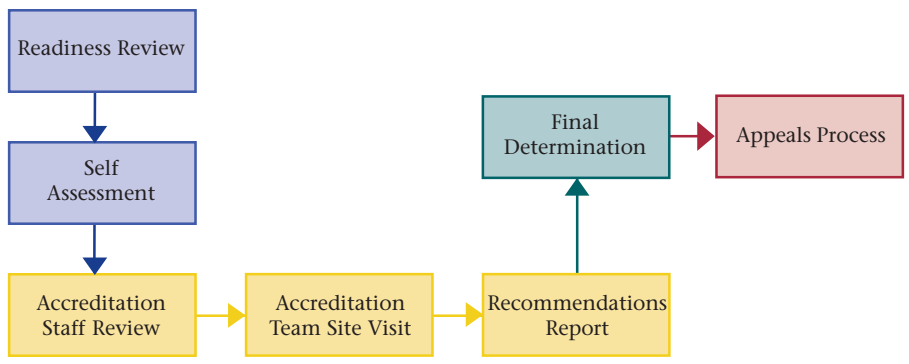
The Governing Board reviews the recommendation and votes on whether to award accreditation status. As a result of the assessment, the applicant may be fully accredited, conditionally accredited, or not accredited. If the applicant is conditionally accredited, it should be given a specific length of time to improve performance as required to achieve full accreditation status.

If an applicant doesn’t agree with a decision made on a waiver request or during the accreditation process (e.g., it believes it should have a different status or met a certain standard that the reviewers determined they did not meet or partially meet), it should be able to appeal to an appeals board.

The accrediting entity should offer pre-qualifying preparation assistance that includes the orientation of applicant staff to the accreditation process, provision of readiness review and self-assessment tools that are developmental in design and use, and references for available consultation on avenues to meeting and exceeding standards.

If the accrediting entity learns about an applicant not meeting a standard or requirement after the applicant has been accredited, the accrediting entity should be responsible for investigating and determining whether or not the accreditation status should be revoked. Health departments that lose their status should be permitted to re-apply after a period of time.

CONFORMITY ASSESSMENT PROCESS



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CONFORMITY ASSESSMENT DISCUSSION

The recommended six-step conformity assessment process is fairly standard and was considered by the Steering Committee to be appropriate for public health. The first step is a readiness review which utilizes a checklist describing what is needed and what should be reviewed before completing the self-assessment. The second step is a self-assessment to make as much information as possible verifiable prior to a site visit. This step ensures that only agencies that are ready will be reviewed. At the third step, the accreditation staff determines whether the health department is ready for assessment. The site visit is the fourth step, which is necessary to validate the health department's self-assessment and thus assure that the process is perceived as one that is credible. Individuals who make up the site visit teams would need to be trained and have defined credentials and could be either paid or volunteer reviewers. While paid reviewers can provide stability and quality control in the assessment process, using volunteers is highly valued and can help control costs. At the fifth step, the site visit team holds an exit interview during which they share their findings with the health department staff, and generate a recommendations report. The exit interview also provides an opportunity for the applicant to share thoughts or concerns about the review process. The last step of the conformity assessment process is the final determination. This decision is made by the Governing Board.

The Steering Committee agreed there should be levels of accreditation status – fully, conditional and not accredited. The decision to allow for conditional accreditation status, ultimately, was based on the national program's goal to improve health department performance. This goal will be met to the extent that health departments volunteer to participate in the system and are successful at becoming fully accredited. Providing for conditional accreditation is likely to attract a larger pool of applicants, as those who are uncertain of their chance of achieving accreditation would be more likely to apply. Therefore, this provision can be a good strategy to engage health departments in the process. The national program also could work to make specific technical assistance available for those that receive conditional recognition, thus providing another mechanism to achieve the program's goal of quality improvement.

Expecting that there will be times when an applicant may want to contest a decision made during any step of the accreditation process, including accreditation status or a waiver request, the Steering Committee decided that an appeals process should be established. Options for creating a deciding body were discussed, but final determination was not made. One of the options explored included developing an appeals committee comprised of Governing Board members, external members, and an arbitrator, with the accrediting entity making the final decision. A second option was to have an independent committee review the appeal and share their findings with the accrediting entity that would still make the final determination. The Steering Committee felt that the specifics regarding the appeals board should be decided by the new Governing Board.

It is important that accredited health departments maintain a certain level of performance. If the accrediting entity learns or has reason to suspect that a health department has fallen out of compliance, they will be re-reviewed to determine whether their status should be revoked. If their status is revoked, the health department would be allowed to reapply; however, the length of time before they are able to do so is not yet determined. Such consequences help ensure that the accrediting entity and the national program are viewed as credible.



FINANCING

Financing the development and operation of the accreditation program can be considered in three phases. In the initial development phase, a consortium of funders interested in promoting public health improvement should be sought to fund the start-up organization itself. In the initial operating phase, funding should be a mix of direct support from funders for operations and revenue from services, such as applicant fees and training fees. Over time, more of the funding should come from the applicants, assuring a customer focus in the accreditation program. In full operation, the goal is for the accreditation program to be self-sustaining with reasonable fee revenues from the application fees and accredited departments. Support for applicant fees could still come from other sources. The accreditation program should advocate for and promote incentives and capacity building in health departments.

Financing the Initial Development and Operations of the Accreditation Program

The goal of the start-up phase should be to maximize the credibility of the accrediting entity and its cost effectiveness. It will be important to simplify processes wherever possible to promote efficiency for the applicants and accrediting entity. The principal start-up activities should include securing leadership, negotiating contracts with vendors and consultants, developing the standards, creating the assessment process, developing information systems, and conducting beta tests or pilot programs. Other start-up activities, such as marketing to applicants and potential funding sources, managing an application process, recruiting and training site visitors, and managing the assessment process through an initial round can be tailored to the number of applicants expected.

The incorporators should finance the initial legal work to establish the non-profit corporation, provide in-kind services to refine the business plan, and work with a consortium of grant-makers, government agencies, and organizations of state and local health departments to finance the start-up of the voluntary national accreditation program.

Potential private sector funders include grant-making organizations promoting health care quality improvement, public health performance improvement,

and general government improvement. Within the government sphere, the U.S. Department of Health and Human Services agencies (Agency for Healthcare Research and Quality, Food and Drug Administration, and Centers for Medicare and Medicaid Services as well as CDC and Health Resources and Services Administration) are most important, but the Environmental Protection Agency (environmental health, toxicology), the Department of Agriculture (food safety and WIC), and the Department of Homeland Security (bioterrorism response and emergency management response) should be interested in promoting continuous quality improvement through accreditation. The financing plan should recognize that sponsoring organizations and health departments could be willing to provide in-kind contributions and volunteer services. Examples include providing space and equipment, volunteers serving on committees, assisting in the recruitment of funders, and/or assisting in training and peer review.

Financing the On-going Operations of the Accreditation Program

On-going operations costs include those related to maintaining the standards, training and supervising the site visit teams, administering and evaluating the program, maintaining the supporting information systems, and promoting research.

Operations should be funded in part by the applicants, with other funding sources to decrease the burden on them. Having applicants help pay for the accreditation operation increases the connection between the costs and the value to the target market. Additionally, applicant fees for a voluntary program build in cost control signals for the operation and help keep cost containment a high priority.

The application fee should be designed to offset the accrediting entity's costs. Working with states and federal agencies, the accrediting entity could support plans for treating fees as allowable costs or indirect costs in grants and contracts, subsidizing fees of health departments, etc. The accrediting entity also should work with applicant health departments to support budget requests for funding accreditation applications by providing data on the cost-effectiveness and value of accreditation.

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Other funding sources may include organizations at the national, state and local level that seek to promote performance improvement and continuous quality improvement in public health services, and organizations that use information about performance and quality in decision-making. The accrediting entity should work with federal agencies to consider application fees and health department accreditation costs (self-assessment, site visit, training, and other direct costs) as allowable costs in grants, reimbursement fees for services, contracts and cooperative agreements.

Controlling the Cost of the Accreditation Program

Affordability of fees is critical to success, particularly when the value of a voluntary national accreditation program is being established. Affordability should be measured by the actual fees charged, by the cost of the process to the applicant, and by the perceived cost effectiveness of the operation.

The fees and the costs of becoming accredited should be commensurate with the value of accreditation to the applicants. The costs of the accreditation program's operation should be commensurate with the value of accreditation to the public's health and to the sponsoring agencies.

The accrediting entity should design:

- A streamlined accreditation process making maximum use of electronic data exchange.
- Standardized formats that can also meet the needs of funding agencies and other oversight bodies.
- Goal-directed self-assessment and site visit assessment procedures.
- An orientation to the accreditation process for applicants.

Benchmarks and best practices for completing the application and conducting the self-assessment should be made available in the pre-application orientation, providing guidance on cost-effective ways to complete the processes and assisting applicants in controlling costs. Providing sample policies from high performing agencies, setting guidelines on the maximum length of documentation, and providing for the use of existing data formats to submit information are other techniques to control applicant costs.

The accrediting entity should establish its architecture to control costs. Volunteer committees should be used to develop and maintain the standards, with significant participation by accredited state and local public health departments and academics. The standards and benchmarks used in accreditation should be simple, not complex. The accreditation cycle should be reasonably long, using interim data submissions and targeted follow-up on improvement plans to assure on-going attention to transforming public health departments into high performing, continuously improving organizations.

In the initial development and operation phases, in-kind contributions, volunteer services, and contractual services should be highly valued by the accrediting entity, but there also should be sufficient investment in training and supporting site review teams to assure standardized assessments and efficient administration. As the program develops and the number of accredited public health departments grows, the accrediting entity should reassess the balance of volunteer, in-kind, and contractual services to assure continuing cost effectiveness.

The accrediting entity should provide services to encourage cost controls in accreditation processes at the applicant level. It also should work with state and local public health departments, designing its assessment processes to streamline the applicant's work while maximizing the value of the self-assessment, data collection, site visit, and feedback activities. Moreover, the accrediting entity should collect and aggregate data on the costs of the accreditation process, including costs to applicants. These data should be available to applicants for benchmarking their costs and identifying potential cost controls. Finally, making use of a recognition/approval process through which existing state-based programs could demonstrate conformity with national standards is another way to keep costs down.

FINANCING DISCUSSION

The Finance and Incentives Workgroup was charged with examining the possible ways in which a voluntary national accreditation program could be financed. Working closely with consultant Michael Hamm, the Workgroup examined the ways existing accreditation programs were funded. The Workgroup analyzed this information in light of their own public health administrative and business experiences. Within the Workgroup, consensus emerged around several key points on starting an accreditation program:

- Financing the start-up of an accreditation program should be considered separately from financing its on-going operations.
- Those who finance the accreditation program have strong influence over the content and the operation of the program.
- An accreditation program for publicly-funded agencies needs to consider cost control for applicants as a priority in demonstrating its value.

Financing the Initial Development and Operations of the Accreditation Program

Financing start-up through a consortium of funders was identified as a key strategy. A consortium of funders improves the stability of the new program financially and signals the breadth of interest in accreditation in the field. The support of legislators and chief executives has been very important to the development of state public health accreditation and improvement programs. Attention to their interests and concerns will be important in developing a consortium of funders.

Similarly, demonstrating in-kind and volunteer support by public health organizations and leadership is crucial in signaling interest in the program and in controlling costs. Where this support has been weak, accreditation and certification programs have withered, for example the recent physician office certification program at the American Medical Association.

Transparency in financing the start up is very important. The potential for a voluntary accreditation program to succeed will be influenced by the “company it keeps” in

the very beginning. Other accrediting organizations depend heavily on applicant fees to support the program, but that is not how they started. Most programs examined had been financed by trade organizations in their start up periods. Commentary in the public comment periods and discussion within the Steering Committee reflected concerns about capture of an accreditation program by single interests, however benign their intentions.

Cost containment in the start-up phase is an important signal to the field. However, an open, highly participatory process of developing the standards, the measures and the conformity determination process is critical. The business case developed for the Steering Committee’s consideration placed significant emphasis on the need to support extra cost in time and resources invested in full participation in developing these elements of the accreditation program.

In the start-up phase, attention to operational efficiency and to standardizing data and procedures for the future applicants will be interpreted positively. Complaints against accrediting programs seem to focus heavily on these issues. The Finance and Incentives Workgroup’s recommendations and the business case developed for the Steering Committee’s consideration included options to enhance efficiency from the outset of operations.

The Finance and Incentives Workgroup examined the pool of potential major funders of the start-up: it is not large. As the business case (see Appendix G) was developed for the recommended model, the Workgroup recognized the long lead time before the program could become self-sustaining. Potential funders will need to be willing to wait for results. At the same time, the Workgroup and the Steering Committee recognized the critical need for the accreditation program to be funded by its beneficiaries, even though many health departments will need assistance in paying fees and achieving conformance. (See the discussion of *Financing the On-going Operations of the Accreditation Program*, and Incentives, below.)

Looking at the experience in other accreditation programs, the Workgroup noted that interest in influencing the quality of the services being accredited has been important in attracting supporters.

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Alternatively, input from the public health field demonstrates that there is great concern about capture of the accreditation program by one or two parties. The Workgroup and the Steering Committee have identified a long list of potentially interested parties, few of which have the capacity to be major funders. Reaching out to many partners in forming an in-kind-funding consortium is an alternate strategy for sustaining a balanced accreditation program. In its final recommendations, the Steering Committee included both concepts: a consortium of financial backers and a broadly-based cadre of in-kind supporters.

Financing the On-going Operations of the Accreditation Program

After examining a number of national accreditation programs' finance structures the Workgroup recommended that on-going operations be funded primarily by the applicants and accredited agencies through fees.

The Steering Committee discussed this approach extensively in order to reconcile it with the resource constraints within public health. The final recommendation is that on-going operations be funded primarily by the applicants and accredited departments through fees, with other funding sources to decrease the burden on applicants.

The Workgroup emphasized the important role that paying fees plays in assuring that the customers, the accredited health departments, have a strong voice in the operation of the accreditation program. The Steering Committee understood that applicants' willingness to pay fees help keep the resources focused on public health outcomes and continuous quality improvement as the final product of accreditation. By bringing other funding sources into the on-going operations, the application fees needed to sustain operations can be kept low enough to attract a wider range of health departments to seek accreditation.

The Workgroup explored alternatives that would incorporate accreditation and performance improvement costs into indirect cost agreements, incorporate these costs as allowable costs in fees for services, and create "scholarships" for under-resourced health departments. These alternatives assure that funding for operations at

least partly flows through the applicants, not directly to the accrediting program. The final recommendations of the Steering Committee state that "the accrediting entity should work with federal agencies to consider application fees and health department accreditation costs as allowable costs" These issues are discussed further below (see discussion on Incentives).

Controlling the Cost of the Accreditation Program

The Workgroup explored the sources of costs in the accreditation program from the perspective of program operation. One key step was to identify fully the components of operating costs. At the urging of public commenters and the Steering Committee, the Workgroup exploration also included the costs to the applicants. This is not commonly done, and the information from other programs was largely anecdotal. The costs centers identified included such items as training, data collection, analysis, and staff time, but attaching dollar costs to these centers exceeded the Workgroup's capacity. As governmental agencies on strict resource diets, health departments are especially sensitive: their concerns center on priority-setting for quality performance and health improvement. Therefore cost containment for both the program and the applicants could be considered in the business strategy, but placing dollar values on the applicant component had too many variables to be practical. The final recommendations by the Steering Committee reflect many cost control decisions. Formally recognizing applicant costs plays an important part in establishing credibility, as does having an efficient operation. To be "marketable," the costs have to be commensurate with the perceived value of accreditation.

The Workgroup also noted the important role that "products sales," such as training programs, technical assistance, consultations, and proprietary systems, have played in supporting other accreditation programs. Most have firewalls to assure that the conformity process remains uncompromised. The Steering Committee discussed this issue extensively, concluding that the risks of product sales outweighed their value. The final recommendations limit such activities to training in the application process and explication of the standards and measures. Product sales are an extremely limited revenue source for public health department accreditation.



Reliance on volunteer expertise, in contrast, is highly valued, and does help control costs. The incorporation of volunteers into standards development and measurement development committee work and the use of volunteers in the site reviews for the conformity assessment process are two very important recommendations for accreditation program operation. At the same time, the Workgroup noted that having a paid team leader is an alternative model that provides stability and quality control in the conformity process.

The role of state-level accreditation and performance improvement programs in the future of a voluntary national accreditation program was considered from a cost and financing perspective by the Workgroup. From this perspective, doing accreditation through an established vendor or franchisee can enhance credibility, expand the "market," increase coordination at local and state levels, and has a number of other attractions. However, while the actual cost to the vendor for conducting conformance reviews is lower, the full cost of accreditation to the applicant may well be higher. The accrediting program has to assure that the assessments by the vendor or franchisee are consistent with all other decisions and that the same standards, measures and interpretations are used. The Governing Board of the national accreditation program makes the final decisions. These administrative and training requirements are significant costs. The applicant still pays the accreditation application fee and the cost of the site review, as well as the costs of oversight of the vendor or franchisee.

The final recommendations from the Steering Committee include developing agreements with existing state accreditation programs where these are interested and sufficiently consistent with the national entity. This is a well-reasoned consensus based on rigorous and intense engagement with the available data and experiences.

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INCENTIVES

When surveyed, public health leaders identified quality and performance improvement, consistency among health departments, and recognition by peers as the most important benefits of accreditation. In the developmental phases of the voluntary national accreditation program, incentives should be uniformly positive. Incentives should include the following:

High Performance and Quality Improvement

Among state and local public health departments there is a high value placed on performance improvement and continuous quality improvement. A successful accreditation program should provide a transforming process that supports these goals.

Recognition and Validation of the Public Health Department's Work

A successful accreditation program should be credible among governing bodies and recognized by the general public, providing accountability to the public, funders and governing bodies (legislatures and governors at the state/territorial level; tribal governments; and boards of health, county commissions, city councils, and officials at the local level). The accrediting entity should establish an information program which promotes the value of accreditation to the public and key stakeholders. Accredited public health departments should receive rights to use credentials in promoting their work to their constituencies and in seeking access to grants, contracts, and reimbursement preferences. The accrediting entity should provide documentation, promotional materials for customized use, and specialized support to accredited public health departments. In addition, the accrediting entity should maintain an active program promoting the value of quality and performance improvement in public health and the role of accreditation in encouraging and documenting continuous improvement in public health departments.

Access to Resources and Services to Undergo the Accreditation Process

To encourage state and local public health departments to seek accreditation, the accrediting entity should provide assistance for the application process as detailed under "Conformity Assessment Process" (page 28). The accrediting entity also should work with potential funders to develop scholarship programs and encourage peer

consulting services for departments needing assistance in specific domains. There should be no penalty (other than expended costs and fees) for terminating the application process during the pre-qualification process or before an accreditation decision is reached.

Improved Access to Resources

The accrediting entity should partner with public health organizations, foundations, and governmental agencies to promote incentives for accredited public health departments.

These can include:

- Access to funding support for quality and performance improvement.
- Access to funding to address gaps in infrastructure identified in the accreditation process.
- Opportunities to pilot new programs and processes based on proven performance levels.
- Streamlined application processes for grants and programs.
- Acceptance of accreditation in lieu of additional accountability processes.

Accreditation also has been shown to enhance recruitment and retention of a high quality work force through reputation and an enhanced working environment.

Access to Support for Continuous Quality Improvement

The accrediting entity should maintain active support for continuous quality improvement among accredited public health departments. The components of this transformational practice support program may include in-person and Web-based services, best practices exchange, peer-group data exchange and analysis, and similar resources. Leadership awards may be developed as the accreditation program matures.

INCENTIVES DISCUSSION

Accreditation is a tool for transforming public health departments into higher-performing, quality-oriented organizations. For those committed to this transformation, this program is designed to assure that participants and non-participants become higher performing, more quality-oriented public health departments. The incentives to use this particular tool fall into two categories: benefits from recognition and supports for transforming (e.g., financial assistance, technical assistance, etc.). The Workgroup and Steering Committee both were adamant about including only positive incentives in the program. Through deliberations, incentives that appeared restrictive or coercive or significantly shifted resource patterns were discounted as negative. Incentives that changed relationships between the accrediting entity and the accredited departments, such as access to special training or consultative programs, were recognized as conflicts of interest and also discounted. Incentives cannot be punitive to non-participants if the program is to have a “field-wide” impact on performance and outcomes.

Exploring the options for incentives to become accredited and evaluating the challenges was revealing. Financial incentives for participation, such as better access to grant funds, training programs, contracting opportunities, and enhanced fees, may exacerbate problems of smaller, more rural or weaker health departments by drawing the available resources away from them. If the goal of accreditation is improved health status for all, this redirection is seen as counterproductive. Although recognition for high performance is considered an important benefit, even that is viewed with concern as potentially decreasing access to resources by others. Hence, in both financing the program and developing incentives, the Steering Committee recommendations are intended not to be exclusive or too closely tied to the accrediting entity itself. The recommendations are intended to promote efficiency and value.

The Steering Committee’s final recommendations also recognize that the accrediting entity itself has limited capacity to provide incentives other than recognition and confirmation. It will need to seek out others – government funders, foundations and payers for health

care and public health services, for example – to provide incentives. The Steering Committee struck a fine balance among competing priorities to identify the types of incentives that will be most useful for implementing a voluntary national accreditation program.

The Workgroup and the Steering Committee also articulated factors that might influence others to provide incentives. Policy-makers such as legislatures, county and municipal officials, and boards of health may be encouraged to support the start-up and the participation of state and local health departments if they can see:

- Opportunities to measure performance on an appropriate set of services at a consistent level of quality.
- A connection between state and local circumstances and national perspectives on key services.
- A single process for assuring readiness and ability to perform.
- A single process for accountability.
- External validation that health departments are under-resourced and of the resultant disparities in health outcomes in those communities.
- Information for advance planning to shore up infrastructure capacity.
- A tool for assessing wise investments over the long term.

Foundations and state and federal government agencies may participate in providing incentives in order to promote their agendas for high quality public health services and improved health outcomes, if accreditation makes the case for transformation.

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PROGRAM EVALUATION

A logic model has been developed to serve as the framework for evaluation of a voluntary national accreditation program. Evaluation of the program should be highly emphasized throughout the process of planning, development and implementation. The associated costs need to be factored into the program's budget.

Furthermore, the accrediting entity should determine from the outset and in a transparent way which evaluation results will be kept confidential and which will be shared publicly or made available to researchers and others. The evaluation plans should be flexible enough to be implemented by many different organizations (i.e., the national accreditation program doesn't have the monopoly on data or evaluation). In addition, quality data collection is critical, and data should be collected in a standardized way that allows it to be integrated with data from other systems.

Aspects of the program to evaluate include those described as follows.

Effectiveness of the Accrediting Entity

- Is the accrediting entity appropriately staffed and are staff members performing well?
- Does the accrediting entity use results of evaluation to improve the accreditation program?
- Is the financial performance meeting the goals set by the Governing Board?

Accreditation Process

- How much staff time (from both applicant and accrediting entity) is required to complete the accreditation process?
- Are the required activities for each step of the accreditation process clear and understandable to all participants?
- How useful are the various types of training and technical assistance?

Marketing and Customer Satisfaction

- How many agencies are participating in the accreditation process and what are their characteristics?

- How satisfied are participating agencies with the accreditation program?

Accreditation Standards and Measures

- Are the standards appropriate? Do they need to be changed?
- Are the standards and measures reliable and valid?

Improved Performance of Accredited Agencies

- What improvements in agency performance have resulted from participation in the accreditation program?

Contribution to Evidence Base

- Is the accreditation process capturing data to support key research questions?
- Does the accreditation program have policies and processes in place to support the use of accreditation data by researchers?

Credibility of Accreditation Program

- Is the accreditation program perceived as credible by potential applicants and decision makers?

PROGRAM EVALUATION DISCUSSION

The logic model (see Appendix F) is intended to link accreditation activities and outputs to both short-term outcomes (e.g., changes in health department capacity and practices) and long-term outcomes (e.g., changes in health indicators). However, the importance of not suggesting an automatic link between the short-term and long-term outcomes was noted by the Steering Committee. Improving the capacity, programs and/or operations of a public health agency has not been proven to lead to improvements in health indicators (such as infant mortality or water quality). Conversely, these outcomes can improve for reasons that have only limited relationship with health department performance. Many other contextual variables (independent of the work of health departments) affect these long-term outcomes. Currently, the evidence base to support the linkage between specific standards for public health (such as those specified in the National Public Health Performance Standards Program) and improved public health outcomes is very limited. With

these caveats, the Steering Committee embraced the logic model as a framework to guide evaluation of the voluntary national accreditation program. The Steering Committee also noted that the accreditation entity has an obligation to participate in developing and facilitating a research agenda around the short- and long-term outcomes of accreditation, and thus to contribute to the evidence base. (See a more detailed discussion about research below.)

A central responsibility of the accrediting entity's Governing Board is to ensure ongoing evaluation of both the processes and outcomes of the national accreditation program and to use this information for continuous quality improvement. Evaluation activities must be sufficiently funded in all phases (i.e., the developmental, initial operation and full operation phases) of a new program. Evaluation will be critical to the success of the program for many reasons. Chief among them are the need to assure that the program is functioning in a way that achieves the program goal of promoting quality and performance improvement; to assess and respond to issues around customer satisfaction; to evaluate efficiencies and cost inputs; and to modify marketing strategies based on information that is collected.

The Steering Committee recommended a robust set of domains for program evaluation (page 37). In its deliberations, the Research and Evaluation Workgroup noted that some evaluation questions should have higher priority in the early phases of the accreditation program, and to that end recommends the following sequencing.

PRE-LAUNCH

Formative evaluation

- Which of the implementation processes under consideration is more likely to support performance improvement?
- Are the proposed accreditation standards consistent with the principles recommended by the Steering Committee?
- Is the proposed accreditation process perceived by potential applicants as offering sufficient benefits?

PHASE 1

Evaluation of inputs

- Agencies' readiness to apply and maintain accreditation.
- Perceptions of the value of accreditation.
- Agency interest in pursuing accreditation.

Evaluation of strategies

- Accreditation & re-accreditation processes (self-assessment, external review).
- Support for accreditation by policy makers (elected and appointed; local, state, national).
- Incentives for participation.

PHASE 2

Evaluation of outputs and outcomes

- Ability of accredited agencies to use resources more effectively.
- Willingness of accredited agencies to seek re-accreditation.
- Percentage of population served by accredited agencies.

PHASE 3

Evaluation of outcomes

- Improved outcomes (staff competency, inter-agency collaboration, quality of services) in all public health agencies.
- Strengthened organizational capacity of accredited agencies.
- Percentage of population served by accredited agencies.

While Research and Evaluation activities are linked, the Steering Committee listed separate definitions of "research" and "evaluation" in the project glossary (Appendix H). This distinction was important, as it is recommended that the Governing Board ensure that program evaluation occurs, and also that the Governing Board actively promote research conducted by others that would benefit the national program. The following section discusses principles around research that would support the national program.

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RESEARCH DISCUSSION

The accrediting entity and Governing Board are specifically charged with actively encouraging research that would benefit the program. The Steering Committee noted that an attendant research agenda should examine issues related to the importance and value of a voluntary national accreditation program, as well as the desired outcomes as listed in the logic model. What constitutes a best practice also should be defined.

Although the Steering Committee did not delve into this level of detail, the Research and Evaluation Workgroup generated several principles recommending that the accrediting entity establish a research and evaluation committee. The primary responsibilities of this committee would include recommending priorities for evaluation and research as well as identifying which areas are most appropriate for internal evaluation and which for external research. Early tasks for this committee should include identifying (1) the basic “demographic” data that should be collected from health departments making inquiries about and applying for accreditation and (2) the data about the accreditation process that are needed to support evaluation. It would also address the many implications of data needed to support research, e.g., determining what data should be made available for research purposes and how they are collected (i.e., to the degree possible it would be preferable to easily integrate them into other available data).

Additional principles regarding research that the Workgroup identified include the following:

1. The accrediting body should advocate for resources to support relevant research.
2. Research should be conducted by external parties (i.e., no formal ties to the accrediting entity) to avoid real or perceived conflicts of interest.
3. The accrediting body should establish policies that allow for the use of data collected through the national accreditation program by public health systems researchers. These would include policies on confidentiality and data use, including reasonable fees for use of the data.
4. The accrediting body should coordinate with public health organizations that engage in routine collection of data to encourage them to collect data that would inform the research agenda.
5. As the evidence base emerges from research, the accrediting body should use it to improve the national accreditation program.

PUBLIC COMMENT DISCUSSION

Establishing a public comment period for review of the draft recommendations was viewed by the Steering Committee as a very significant component of their exploration. It was critical to understand how potential applicants viewed a voluntary national accreditation program for state and local governmental public health departments, and make the recommendations responsive to the findings. It was also very important to sample the response from state and local policymakers and to respond to their interests.

The project consultant, Michael Hamm, fielded an opinion survey to state and local health officials as part of a market research effort. That effort is described on page 12 of this report. Four additional mechanisms were established to receive public comment:

1. Presentations (in person, conference call, and satellite broadcast – see Appendix D).
2. Speaker and participant feedback forms (distributed during the in-person meetings).
3. Online survey (accessible through www.exploringaccreditation.org).
4. E-mail (feedback@exploringaccreditation.org).

Speaker feedback forms

Speakers from all of the presentations completed a speaker feedback form. Generally, the in-person discussions were followed by a question and answer session, rather than providing a forum in which opinions are expressed. The most common questions were about the cost of participation, the time required to complete the process, and when implementation will occur. Additionally, concern was expressed that although the program is called voluntary, it will become mandatory over time.

Written responses

A total of 540 individuals responded in written format. See Appendix I, Tables 1, 2, and 3 for the demographic information that was collected from the respondents. The respondents were not geographically diverse, with over half coming from U.S. Public Health Service Region V. In addition, the majority of respondents were from local health departments. The percentage of state and local health departments relative to their respective

universes is not available, as more than one individual could respond from the same health department. It is important to note that job title was not requested, and therefore the responses were not necessarily from the health official.

Survey participants were asked to respond to three closed-ended statements, indicating the degree to which they agreed (strongly agree, agree, neutral, disagree, or strongly disagree). With respect to “The model is understandable” (Appendix I, Table 4), 73 percent (349) of the respondents indicated that they agree or strongly agree, six percent (27) indicated that they disagree or strongly disagree, and 21 percent (100) were neutral. With respect to “The model is feasible for implementation” (Appendix I, Table 5), 46 percent (216) of the survey respondents indicated that they agree or strongly agree, 28 percent (83) disagree or strongly disagree, and 35 percent (164) were neutral. In response to “Our health department would seek accreditation under this model” (Appendix I, Table 6), 45 percent (195) of the respondents indicated they agree or strongly agree, 18 percent (80) indicated they disagree or strongly disagree, and 36 percent (158) were neutral.

These data also were analyzed to see if there was a difference between how individuals from state and local health departments responded to these questions. In general, the responses were similar (Appendix I, Tables 7-9). (Please note that the percentage of respondents was provided in order to present a relative picture of the responses.) Although the percentage of state health departments that rated feasibility for implementation and likelihood of seeking accreditation under this model appears to be a bit higher than local health departments, a significant difference in the responses from these two groups cannot be inferred because of the smaller number of state health department respondents.

Finally, these data were analyzed to evaluate whether state and local health departments of varying sizes (defined by size of the jurisdiction served) were more or less likely to seek accreditation under this model (Appendix I, Table 10). For these purposes, small health departments are defined as those serving populations of 0-49,999 (n=137); medium serve 50,000 to 999,999 (n=204); and large serve 1 million or more (n=51). There is a statistically significant difference between the

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small and medium health departments, in that the smallest health departments are less likely to seek accreditation under this model. There is no statistically significant difference between the responses from medium and large health departments.

Open-ended questions also were posed, and a summary of the responses follows.

1. What benefits of accreditation are most important in your thinking about supporting accreditation?

A number of benefits were cited in response to this question (Appendix I, Table 11), and the terms in bold font indicate those used on the corresponding tables. Three themes were mentioned frequently (at least twice as frequently as any other of the cited benefits). The most frequently mentioned benefits were those associated with increased recognition, which included increased public support; increased public awareness; better visibility; credibility to the community, governing bodies and elected officials; and clarity of expectations. Other benefits cited very often were consistency among health departments (which included the value of having nationally-agreed upon standards) and improved quality of services provided and improved performance (QPI).

Benefits that were cited less frequently included accountability and validation (including objective assessment of work), as well as increased funds and tie to funds (i.e., accreditation would be viewed as a benefit if accreditation status were tied to receiving additional funds). The notion of outcomes – improved community outcomes, and better outcomes of the health department in general – received several mentions, as did an enhanced evidence base and benefits to staff (improved morale, collaboration among staff internally, and improved recruitment and retention efforts). Other items mentioned included accreditation as a tool for quality assurance and a means to identify best practices, and that ease of use, availability of comparison data, streamlined grants application processes and access to technical assistance and experts would be positive benefits.

Another theme that emerged, however, was that there are no benefits to be gained.

2. What issues or problems are most likely to result in your deciding against supporting accreditation?

By far, the most frequent responses to this question were issues associated with cost and time (Appendix I, Table 12). A predominant perception was that accreditation is very expensive, and that new funds are needed or, in order to pay for it, health departments would need to shift money from other programs, essentially choosing between accreditation and providing services. Additionally, it was viewed as a time-consuming and complex/difficult process, and many respondents indicated that they felt they did not have sufficient staff, and/or that staff time also would be shifted from services to undergoing necessary training and then completing the process. Several respondents questioned whether the cost justified any benefits to be derived.

Others voiced concern regarding the applicability or appropriateness of the program to small health departments. There was concern that small and rural health departments would not meet the standards, and that an accreditation program could result in their elimination or consolidation. Along these same lines, another theme was the need to adjust the program to “fit” different sized health departments/different infrastructures, perhaps by establishing categories.

An additional theme that emerged was the difficulty of obtaining buy-in for accreditation from staff, boards of health and/or elected officials, and the need to market the value of accreditation, particularly a voluntary program, to governing boards and elected officials. Along these same lines, several mentioned that they may not be able to convince those who need to support this of its value if it is indeed voluntary.

Still others saw this as unnecessary, and/or nothing more than a bureaucratic exercise with little to no benefit or tangible results. A number of respondents questioned what the consequences would be of not becoming accredited (as a result of not passing or simply choosing not to participate). Potential consequences mentioned were loss of funding, negative public opinion, and the notion that this could become a political tool.

Other themes noted included the need to clearly demonstrate positive outcomes of accreditation before establishing a national program, and concerns that this will become a mandatory program. Additional concerns were raised that this could be duplicative of current standards-based efforts. Several respondents also directly asked how a national program would work with existing programs, and whether it is acceptable for states to begin or continue to develop their own accreditation or related programs.

Concerns that accreditation could interfere with local needs and priorities were also expressed, as was the need for stronger and better incentives. Finally, a handful of other potential issues and problems were also raised in very small numbers, and they deserve attention as well. They include:

- The difficulty and importance in establishing standards that are clear, measurable, valid, achievable and not political, that are developed using an inclusive process, and that are neither too easy nor too difficult to achieve.
- Concerns regarding a negative effect on staff morale were also noted.
- A few suggestions to make this a mandatory program.
- The need to modify the composition of the governing body, by significantly increasing the number of local health department (LHD) slots, including environmental health representation, deliberately including minority representation, and including board of health members.
- The importance of modifying the logic model and the program to specifically address health disparities.
- Advice to learn from the “mistakes” that JCAHO has made.

These data also were analyzed to determine whether respondents were more likely to identify benefits or issues/problems, or whether they identified neither or both (Appendix I, Table 13). The majority of respondents identified both, and more identified issues/problems only than benefits only.

The data were also analyzed to compare the number of benefits cited among those most likely to seek

accreditation under this model (respondents who answered “agree” or “strongly agree” to the question), least likely (“disagree” or “strongly disagree”), and uncertain (“neutral”) (Appendix I, Table 14). A similar analysis was done to compare the number of issues/problems cited by the three different groups (Appendix I, Table 15). Those who are most likely to seek accreditation identified the greatest number of benefits, possibly suggesting that the clear and compelling benefits may be a key to maximizing participation in a national program. In addition, the number of issues/problems identified was fairly similar between those most likely to participate and those who are uncertain, possibly suggesting that attention to potential issues/problems could encourage more participation by those who are uncertain.

Finally, the data were analyzed to identify whether there were differences in the percentages of respondents identifying specific benefits and issues/problems in these three groups (Appendix I, Tables 16 and 17). The respondents most likely to participate were significantly more likely to cite benefits related to recognition (45 percent vs. 19 percent), accountability (12 percent vs. 2 percent), and validation (10 percent vs. 1 percent) than the respondents least likely to participate. On the problems/issues side, respondents in the “uncertain” category were significantly more likely than those in the most likely category to cite lack of time as a problem (43 percent vs. 27 percent). Cost was cited as a problem more frequently by those respondents least likely to participate (69 percent) than those respondents most likely to participate (32 percent).

3. Are there design flaws in the proposed model that the Steering Committee should address?

Overall, responses in this category mirrored the themes above under issues or problems with the model and as a result have been tabulated with that question. Additionally, 41 respondents noted that either they would need more information to provide a sound response to this question, or more time should be devoted to studying the issue.

Although these data do not include a representative sample of potential applicants, they nevertheless

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provided useful feedback to the Steering Committee regarding the proposed model and the readiness of the field to participate in a national accreditation program.

A large majority of respondents (73 percent) agreed that the model was understandable. Slightly less than half of respondents (47 percent) agreed that the model was feasible, with a suggestion that a smaller percentage of local agency respondents than state agency respondents agreed that the model was feasible (44 percent versus 58 percent). Slightly less than half of the respondents indicated that they were likely to seek accreditation (45 percent). For local health departments, the likelihood of seeking accreditation appears strongly related to population of the jurisdiction served. Twenty-four percent of local health departments serving populations less than 50,000 indicated that they were likely to seek accreditation, versus 57 percent of local health departments serving populations of 50,000 or greater.

Increased recognition, consistency among health departments, and improved agency services were by far the most frequently cited benefits of a national accreditation program. The cost and time associated with the accreditation process were by far the most frequently cited problems or issues. Consistent with the findings of the online survey, likelihood of seeking accreditation is associated with the degree of benefits perceived by the health agencies. A wide range of other benefits and problems were cited by respondents. Not surprisingly, respondents who were most likely to participate in a national accreditation program were more likely to cite certain benefits (related to recognition, accountability, and validation) and less likely to cite certain problems (time and cost) than those respondents less likely to participate. The Steering Committee deliberately addressed these aspects in their final recommendations in order to maximize participation.

THE BUSINESS CASE FOR ACCREDITATION

Every person in America has a stake in our public health system and how well it performs. Most people, when asked, can't tell you what "public health" is, what it does and what it means to the safety and good health of their community or family. But research tells us that they sure think it's important and they want more of it, particularly when it comes to protection from broad scale health threats, such as avian flu, or education about making healthier lifestyle choices, for example to prevent obesity or tobacco use.

— *Risa Lavizzo-Mourey, MD, MBA,
President and CEO, RWJF*

The business case presented here incorporates the Steering Committee's decisions, and is matched to the final recommendations. The assumptions in the business model and budget provide information on the effects of decisions about the major variables that influence the costs and the credibility of the recommended voluntary national accreditation program. The findings from external sources have been integrated with the recommendations of the Steering Committee to describe the business environment for a voluntary national accreditation program in the next nine years. The business case examines the market for the proposed accreditation program's product, the volume of work in the development and initial operation phases, and the potential revenues generated from services — the basis for the Steering Committee's decision that this recommended program is feasible.

Demand

The model recommended by the Steering Committee considers all state, territorial, tribal and local governmental health departments to be eligible for accreditation if they apply and meet standards. Presently, there are approximately 2900 local health departments and 57 state and territorial health departments (this number includes Washington, DC). The market among tribal health departments has not been assessed at this time, since this task requires its own participatory process. While representatives of tribal interests have participated in the work to date, this informal process is clearly insufficient.

Feedback from formal presentations and telephone interviews supported the view that there will be initial applicants with enthusiasm. The feedback also suggested that early success can build credibility around the standards and the conformance process, attracting an increasing number of applicants. It was also clear that participant costs are a significant barrier and that skepticism remains about the best use of limited resources. The ability to expand to meet demand is greater than the ability to sustain the effort in the face of lower demand than projected. Therefore, projections of market penetration are very conservative.

A major concern from the field is fear that a national program will become mandatory despite the project's emphasis on voluntary accreditation. This concern shaped final recommendations on incentives from the Steering Committee: incentives should be positive for the accredited departments, but not negative for the unaccredited ones. In addition, the emphasis placed on the voluntary nature of the accreditation program will both stimulate early adopters to become accredited and discourage health departments with significant resource constraints from seeking accreditation early. The latter group will want to see develop a track record that shows resources to support the application process and achieve quality improvement flow to applicants and to demonstrate that accreditation does make economic sense for applicants with resource constraints. Missouri's experience with a fully voluntary accreditation program foreshadows limited uptake of the service until incentives and benefits become clear. The business case is built upon the expectation of gradual uptake as the new entity demonstrates its value to state and local health departments.

A significant number of states have invested in accreditation and performance improvement programs already. The five states in the Multi-state Learning Collaborative funded by Robert Wood Johnson Foundation have populations between 5 million and 15 million. Local public health leadership in these states is very supportive of the concepts of accreditation. In the initial years of operation of a national accreditation program, participation in a national accreditation program may not be seen as adding sufficient value to attract health departments already involved in state level accreditation. Issues to be resolved in the process of

determining whether a state program becomes a participant will include:

1. What will the fees be and what entity is responsible for paying the fees?
2. Is national participation voluntary when the state program is mandated?
3. If a state program declines a partnership, will individual health departments apply separately?

The answers to these questions will influence the numbers of accredited health departments in the early years of the program.

Appendix G, Table 1 projects the market and participation in accreditation services in the initial operating period, taking into account local health departments not currently participating in a state-based program.

Competitive landscape

The greatest competition for a voluntary national accreditation program may be for administrative resources within health departments with existing programs and services. Many health departments will make decisions about whether to seek accreditation based on the cost benefit ratio for expected health outcomes compared with that of existing programs.

We have identified no other national accreditation program for health departments under development at this time.

In contrast, several state-level health department programs exist, but they are not using common standards or processes. Accreditation programs for local health departments in North Carolina and Michigan and performance improvement programs for local health departments in Illinois and Washington State (the only state that also currently includes the state health department in its accreditation or performance improvement program) are established in statutes. Missouri has a voluntary accreditation program for local health departments. As noted above, the model proposes opportunities for these state programs to be determined equivalent and/or to have their accreditation decisions endorsed by the national program. None of these state programs has indicated interest in offering

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their program's services outside its own state. Accreditation by two different accreditation programs, one state and one national, is unlikely to be attractive to state or local health departments unless incentives are both significant and tangible.

Performance improvement efforts using the National Public Health Performance Standards are well-established. These standards are undergoing revision with support from some of the same sources that are supporting *Exploring Accreditation*. Performance improvement models currently result in a similar quality transformation method as accreditation.

At least thirteen other state applications were prepared for the Multi-State Learning Collaborative grant offering in 2005. Representatives from most of these states (health departments, public health institutes, or both) attended a conference on state performance improvement activities in 2006. Their continued involvement has been promoted by the funders of *Exploring Accreditation*. The national program offers some support to continued development of state-level accreditation. While most states do not have accreditation programs under way at this time, there is active consideration of developing them. State-based performance improvement programs have certain advantages in competing with a national program:

- Responsiveness to state/local variations in political philosophy, demographics and economics.
- Direct connection with state and local governmental funding sources.
- Established relationship between state and local health departments, their leadership, and their programs.
- Recognition of geographic variations in public health structures and practices.
- History of performance improvement efforts, including Turning Point.

National health accrediting bodies may consider public health accreditation a worthwhile business engagement providing additional competition. The Joint Commission on Accreditation of Healthcare Organizations has developed a line of business in collaboration with the Health Resources and Services

Administration for Community Health Centers, for example. If the recommended national accreditation program is slow in starting, others may step up. Existing national non-profits with interest in public health, including the sponsors of the *Exploring Accreditation* project, could develop an independent program if the current project does not move forward.

Identifying the Financial Factors for the Business Case

The Workgroup generated a list of the components of the model that influence the cost of developing, implementing and operating a voluntary national accreditation program (Appendix G, [Table 2](#)). While not exhaustive, the list is intended to capture the principle drivers of cost in the enterprise so that a business case can be prepared. Using the model, the Workgroup also generated a preliminary list of revenue sources that may be used to support the new enterprise's work (Appendix G, [Table 3](#)). The Workgroup identified options of design and implementation based on the model and developed a matrix describing three sets of options in order to provide the Steering Committee with a clearer picture of the enterprise and attach cost estimates to the model (Appendix G, [Table 4](#)).

The matrix was developed by identifying the range of options for each variable that would fit the model and the key factors to be considered in selecting an option. The Workgroup included three options for each variable whenever possible. After options were developed for every variable, the Workgroup reviewed the matrix to select the preferred option, based on the criterion that the option was the most likely to allow the model to meet the goals. (Research was identified by the Steering Committee as an important component of the final recommended model. However, only the evaluation of the accreditation program and activities was identified as work to be done by the new entity. Research is to be stimulated by the accreditation program, rather than performed or funded by it.)

Marketing Strategy

The major components of a marketing strategy compatible with the recommended accreditation program include the following:

- A vigorously participatory process for developing standards and measures with strong governing body involvement.

- A streamlined conformance assessment process with emphasis on electronic information exchange and cost-effectiveness from the applicant's perspective.
- A rigorous pilot phase to establish procedures and show value.
- An investment in tangible incentives for applicants.
- An investment in outreach to decision makers and users of accreditation information.

The new voluntary national accreditation program will need to attract and retain applicants/accredited departments in order to demonstrate its value. The business case for the Final Recommendations reflects resource needs for cultivating key supporters: public health professional membership associations, public health institutes, public health department membership associations, public health academic organizations, governmental public health agencies at federal, state and local levels, and foundations with an interest in health and in good government. Negotiating volunteer expertise and in-kind support from existing public health organizations will help solidify support and assist operating efficiency. Securing positive financial and programmatic incentives from government and from private foundations will build credibility for the accreditation program and strengthen the cost-benefit case for becoming accredited.

The recommended model calls for relying on existing standard sets and performance measurement systems as the foundation for accreditation. The preferred options contemplate an efficient conformance process to strengthen the cost-benefit ratio for applicants. These principles provide a strong basis for marketing to health departments seeking to improve performance and health outcomes.

Financial Feasibility

The Steering Committee defined the preferred options for a "reasonable case" operating plan. The revenues from service fees and the operating costs were forecasted for a nine-year period (see Appendix G, [Table 5](#)), and do not take into account the potential fees from the participation of state-based programs. The Steering Committee concluded that a new national accreditation program for public health departments is feasible if key

stakeholders and sponsors are willing to finance a developmental phase of up to three years at an estimated cost of approximately \$2.1 million dollars and to cover an anticipated operational deficit of approximately \$740,000 during the first three years of full operation. (Note: These costs are general estimates that were generated by the Finance and Incentives Workgroup. Upon further analysis these costs are subject to change) The Steering Committee also concluded that long term success will depend upon support of application fees and compliance activities through continuous quality improvement grants to health departments, indirect cost allowances on grants and contracts, and adjustments in fees for services to accredited health departments, just as such sources are available to health facilities to cover the costs of maintaining high quality performance.

Risk Analysis

The model may prove more or less acceptable to the potential applicants than predicted. Fees may be perceived too high, processes too onerous, or standards too complex, resulting in fewer applicants and an overly ambitious financial projection. Alternatively, incentives and benefits could engender more enthusiasm for the program than predicted, resulting in a higher number of applicants and leaving projections of operations growth too conservative. The latter would require tremendous management, but would result in greater financial success than predicted.

Leadership changes at CDC and other major supporting agencies occur frequently. The accrediting entity will need a strategy for bridging future changes in public health leadership. Elements of risk include the willingness and capacity of federal agencies to support voluntary accreditation, escalation of state-based accreditation programs that are not interested in participating in the national program, and foundation support for the developmental phase of the program.

State accreditation programs could proliferate while the development phase is underway and substantially reduce interest in a national approach, particularly if strong incentives are not identified for a national program. Maintaining the momentum to implement the proposal for a voluntary national accreditation program in the near future will reduce this risk, as will the development

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of sufficient incentives for participation in a national program.

Major changes in funding of federal, state and local health departments could affect the start-up of a new accreditation program. If the magnitude of change were as large and rapid as the bioterrorism and emergency preparedness shifts in the past six years, the general instability may complicate development and discourage participation. On the other hand, strongly linking accreditation to strategic change may encourage participation.

Confidentiality of data and political values for accountability and transparency could collide early in the development of the program. Policies will need to be enumerated early and widely disseminated to set expectations before significant data collection begins. A confidentiality dispute or a breach of confidentiality would set the program back substantially.

A significant performance failure by an accredited health department could be disastrous for the credibility of accreditation as a public accountability system. This possibility calls for care in setting expectations at the same time that the new accreditation program is actively marketing, a challenging balance.

Research on the value of accreditation is weak. Change in health outcomes is often held out as the “gold standard,” but research designs to demonstrate effects of accreditation on health outcomes are complex, long, and fraught with methodological and policy minefields. If quantitative analysis and randomized control trials are over-stressed, studies are more likely to produce equivocal findings, leading to a loss of perceived value. Choosing key research projects wisely will be very important. Developing sustained support through expert opinion has worked for the accreditation of direct health care services, but it is periodically challenged despite that consensus.

CONCLUSION

The Steering Committee of the *Exploring Accreditation* project determined that this is a reasonable business case for the recommended voluntary national accreditation program.

APPENDIX A

**STEERING COMMITTEE, WORKGROUP MEMBERS,
PROJECT STAFF, CONSULTANTS, AND
FUNDING ORGANIZATION REPRESENTATIVES**

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EXPLORING ACCREDITATION STEERING COMMITTEE MEMBERS

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A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

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APPENDIX B

QUESTIONS FOR WORKGROUPS



EXPLORING ACCREDITATION WORKGROUP QUESTIONS *Revised February 16, 2006*

MEETING	QUESTION	GI*	SD	FI	RE
OCTOBER	1. Is the general direction of an accreditation system: a. A single national voluntary program? b. A national umbrella for state and/or regional programs? c. Some other model? d. A completely open question? What are the advantages and disadvantages of each option?	X			
	2. What are we trying to achieve with respect to agency performance and governmental public health system performance? What are the advantages and disadvantages?		X		
	3. What should the standards measure (performance, outcome, other aspects)? What are the advantages and disadvantages of each?		X		
	4. What are the benefits and drawbacks of various financing options?			X	
	5. How can costs be minimized and/or confined to those that add value?			X	
	6. Who should finance the system?			X	
	7. What are the most appropriate measures of change resulting from a voluntary national accreditation program?				X
MEETING	QUESTION	GI	SD	FI	RE
JANUARY	1. Should an existing organization be used for the governing entity or should a new one be created? What criteria should be considered to answer this question? a. Who will be the founders and/or incorporators? b. What are the advantages and disadvantages of various governance options for start-up, implementation and on-going operations? c. What principles should guide potential funders in order to avoid a conflict of interest?	X			
	2. What are the responsibilities of the governing body, and how will the first body of members be selected?	X			
	3. What are the most effective and efficient relationships among federal, state and local levels to sustain an accreditation system and how can they be accommodated through the governance structure?	X			
	4. What principles would apply to states that already have LHD accreditation or related programs to be participants in a new accreditation process? What principles would apply to states that already have state accreditation or related programs? (Criteria for a migration strategy would be addressed later by a governing body.)	X			

* GI: Governance and Implementation Workgroup. SD: Standards Development Workgroup. FI: Finance and Incentives Workgroup. RE: Research and Evaluation Workgroup

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

MEETING	QUESTION	GI*	SD	FI	RE	
JANUARY	5. What principles for appeals should be considered for state and local health departments?	X				
	6. What are the principles governing standards where some of the core function/essential public health services are assigned by state or local statute to other governmental agencies? Are the same principles applied to state and local health departments, and if not, how are they different and why?	X	X			
	7. What are the principles governing standards where there are varying public health governance structures? a. In states that have a centralized health department, how are standards applied to the state health department itself, and how are standards applied to their local branches? What are the advantages and disadvantages to various approaches? b. How are standards applied within regions or districts that comprise a group of local health departments? What are the advantages and disadvantages of various approaches?	X	X			
	8. What constitutes the potential range of accreditation recognition and what are the advantages and disadvantages of each approach? Is the desired range the same for state and local health departments? If not, what is the distinction and why?			X		
	9. What domains should be included in the accreditation program for future development of standards, and what are the advantages and disadvantages of each? Are they the same for state and local health departments, and if not, what domains are specific to each?			X		
	10. What is the difference between standards and measures and how should that difference be reflected in the principles?			X		
	11. Where should the bar for standards be set? What are the advantages and disadvantages? Is the bar the same for state and local health departments? If not, what distinction needs to be made and why?			X		
	12. a. What are acceptable operating costs? b. What are the opportunities for controlling costs?				X	
	13. What principles should underlie fees?				X	
	14. Where do the SC-identified goals for accreditation fit into the proposed logic model for a national accreditation system?					X
	15. What existing standards for state and local health departments are empirically linked to outcomes?					X
	16. What principles should guide the development of measures for short-term, intermediate, and long-term outcomes included in the logic model?					X

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EXPLORING ACCREDITATION WORKGROUP QUESTIONS *Revised February 16, 2006*

MEETING	QUESTION	GI*	SD	FI	RE	
MARCH	1. How can the accreditation system attract and retain leadership and commitment from the accredited participants?	X				
	2. Describe the pros and cons of various assessment systems (e.g. self-assessment, peer review, third party, etc.) inherent in most programs for validating agency performance against standards?	X				
	3. What elements need to be considered in structuring governance to protect access to preliminary accreditation results/findings?	X				
	<i>If not addressed in January:</i>					
	4. What principles for appeals should be considered for state and local health departments?	X				
	5. What consideration should be given to existing work such as: a. NACCHO's Operational Definition b. NPHPSP c. State-developed standards d. Other standards?		X			
	6. What principles should be applied to updating standards (e.g., dynamic, periodic updates) ?		X			
	7. How should standards be coordinated among all three levels of government?		X			
	8. Can a selection of specific standards lead to specific incentives, and if so, should we prioritize incentives?			X		
	9. What incentives would most encourage participation in the model system?			X		
	10. What are the barriers, predictable effects, and possible consequences of incentives to be anticipated and how can they be addressed?			X		
	11. Consider the impact on HDs with less capacity (i.e., those HDs with greater capacity typically have helped those with less; the system should not further decrease the capacity of those HDs with less capacity)	These questions were all posed to the RE WG. See recommended revisions, below. Change to "What is the best methodology to pick up on unintended consequences of a national accreditation system?" and move to the June/July meeting.				
	12. Provide comment on (1) how the lack of evidence may affect our current work, (2) ways in which we could extrapolate anything from the anecdotal evidence that exists, and/or (3) what proxy measures of outcome would enable us to establish early in the process some evidence of efficacy.	Staff to draft a principle regarding this issue for the Steering Committee to consider.				
	13. What additional research will result in a stronger evidence base?	Move to June/July meeting.				
14. Evaluate health equity and social justice impact of accreditation.	Delete.					

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

MEETING	QUESTION	GI*	SD	FI	RE
JUNE/JULY	1. Is there a good business case for establishing a voluntary national accreditation system?			X	
	2. What strategies can enhance the business case?			X	
	3. What constitutes a sufficient evaluation framework?				X
	4. How can evaluation efforts of current accreditation and related programs be enhanced?				X
	5. What constitutes sufficient, ongoing research to develop the evidence base concerning accreditation as a tool for improving the quality and outcomes of governmental public health services?				X

* **GI:** Governance and Implementation Workgroup. **SD:** Standards Development Workgroup. **FI:** Finance and Incentives Workgroup. **RE:** Research and Evaluation Workgroup

APPENDIX C

EXPLORING ACCREDITATION FEEDBACK FORM

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

Exploring Accreditation FEEDBACK FORM

Thank you for taking the time to complete this feedback survey. Your comments will assist the Exploring Accreditation Steering Committee in their final deliberations.

	Strongly agree	Disagree	Neutral	Agree	Strongly disagree
1. The model is understandable.	1	2	3	4	5
2. The model is feasible for implementation.	1	2	3	4	5
3. Our health department would seek accreditation under this model.	1	2	3	4	5

OVERALL COMMENTS

4. What benefits of accreditation are most important in your thinking about supporting accreditation?

5. What issues or problems are most likely to result in your deciding against supporting accreditation?

6. Are there design flaws in the proposed model that the Steering Committee should address?

7. Other comments:

Questions continue on the back of this sheet – Please turn this page over.

Exploring Accreditation
FEEDBACK FORM

DEMOGRAPHIC INFORMATION

- Affiliation:
- State Health Department
 - Local Health Department
 - Public Health Institute
 - Academic Institution
 - Elected official
 - Policy Advisor
 - Board of Health
 - Other: _____

- US DHHS region:
- Region 1
 - Region 2
 - Region 3
 - Region 4
 - Region 5
 - Region 6
 - Region 7
 - Region 8
 - Region 9
 - Region 10

- Size of jurisdiction:
- < 25,000
 - 25,000 – 49,999
 - 50,000 – 99,999
 - 100,000 – 499,999
 - 500,000 – 999,999
 - 1,000,000 to 4,999,999
 - >5,000,000

Is your department currently involved in performance improvement, certification or accreditation? yes no

APPENDIX D

LIST OF PRESENTATIONS

LIST OF PRESENTATIONS

ORGANIZATION	TYPE OF FORUM	TYPES OF ATTENDEES	EST. #	DATE
National Network of Public Health Institutes	On-site Presentation	Public health institutes	75	May 10, 2006
OH Combined Public Health Conference	On-site Presentation	Variety of public health professionals	350	May 16, 2006
UT Public Health Association	On-site Presentation	State and local HD employees	70	May 17, 2006
NACCHO Workforce Development Advisory Committee	On-site Presentation	Local health officials (LHOs)	8	May 25, 2006
California Health Executive Association	On-site Presentation	Health administrators	40	June 1, 2006
California Conference of Local Health Officers	On-site Presentation	LHOs	75	June 1, 2006
Council of State and Territorial Epidemiologists	On-site Presentation	State and local epidemiologists	65	June 5, 2006
CO Association of Local Public Health	On-site Presentation	Mostly LHOs	17	June 7, 2006
Michigan Association of Local Public Health	On-site Presentation	LHOs and board of health members	30	June 12, 2006
Local Public Health Association of MN	On-site presentation	LHOs and LHD employees	65	June 15, 2006
NPHPSP users	Conference call	State and LHD employees	50	June 20, 2006
KY Health Department Association	On-site presentation	LHOs	30	June 20, 2006
CT Association of Directors of Health	On-site presentation	LHOs	30	June 21, 2006
IN Association of Public Health Physicians and LHD Organizations	On-site presentation	LHOs and public health physicians	30	June 21, 2006
KS Association of Local Health Departments	On-site presentation	LHOs	20	June 21, 2006

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

LIST OF PRESENTATIONS *continued*

ORGANIZATION	TYPE OF FORUM	TYPES OF ATTENDEES	EST. #	DATE
Metro Washington Public Health Association	On-site presentation	Various public health professionals	7	June 21, 2006
NACCHO	Conference call	LHOs from rural areas	40	June 22, 2006
NACCHO	Conference call	LHOs from metro areas	80	June 27, 2006
MA Health Officers Association	Conference call	LHOs	25	July 11, 2006
VT Department of Health	On-site presentation	LHOs and state HD employees	50	July 12, 2006
IA Association of Local Public Health Agencies	On-site presentation	LHOs and senior staff	100	July 13, 2006
ASTHO Senior Deputies	On-site presentation	SHD senior deputies	50	July 13, 2006
NACo, USCM, NGA, NCSL	Conference calls	State and local elected officials and staff	5	July 17, 18, 25, and 27, 2006
CDC/ASTHO/NACCHO/NALBOH/APHA	Satellite broadcast	Various public health professionals	400	July 20, 2006
Missouri Institute for Community Health	Conference call	Various public health professionals	20	July 21, 2006
NACCHO/NALBOH Annual Conference	Town Hall meeting	LHOs and local board of health members	600	July 26, 2006

APPENDIX E

EXAMPLES OF STANDARDS AND MEASURES

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

The following standards and measures are meant to provide **examples** of what *might* be used in a voluntary national accreditation program. These examples are based on NACCHO’s Operational Definition, the National Public Health Performance Standards Program State Instrument, and the Washington State Public Health Improvement Plan.

These examples have not been approved by the Exploring Accreditation Steering Committee, and feedback is not being sought at this time.

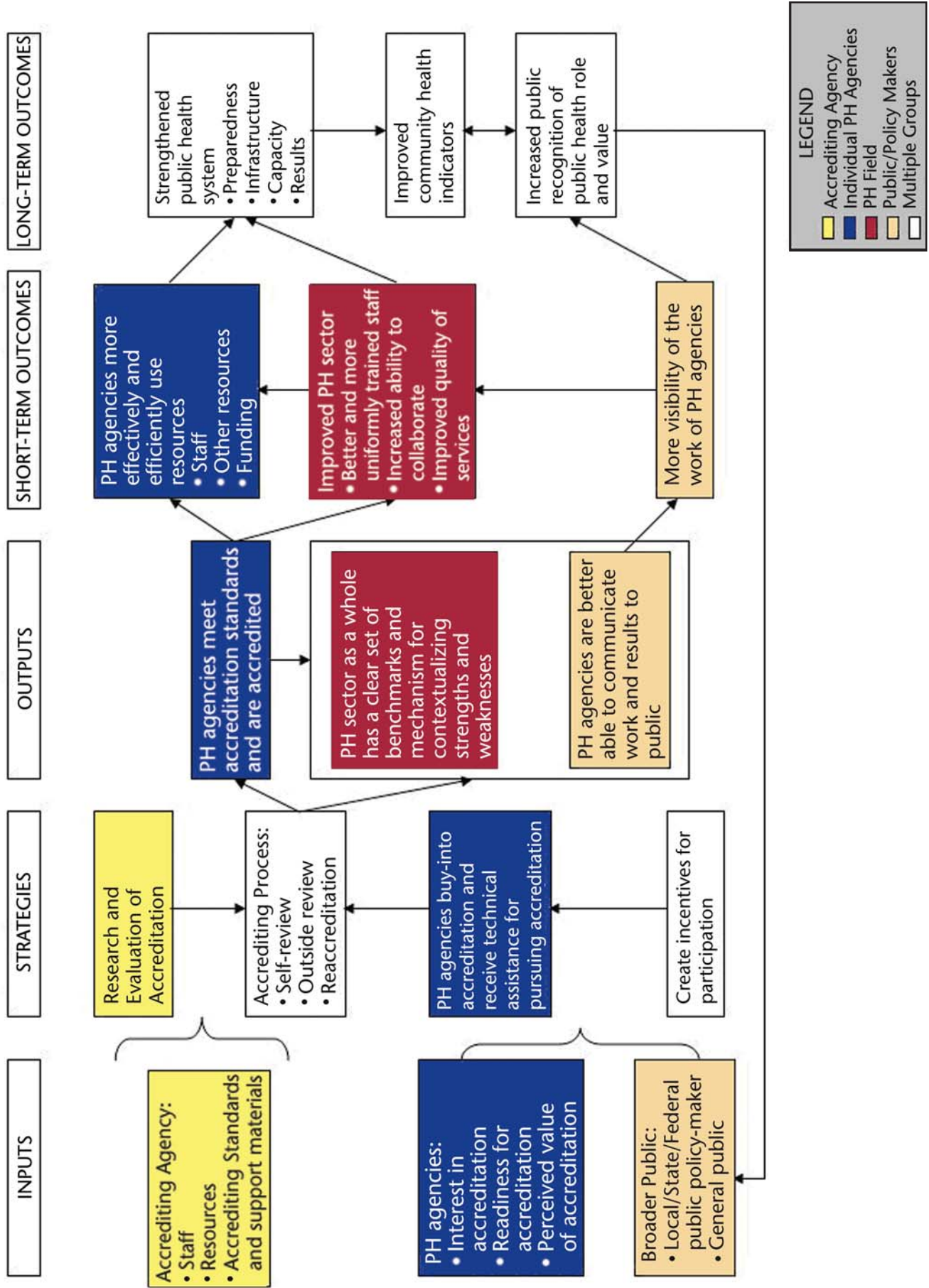
1. Protect people from health problems and health hazards		
	STATE	LOCAL
Standard	Collaborate with public and private laboratories, which have the ability to analyze clinical and environmental specimens in the event of suspected exposures and disease outbreaks.	Maintain access to laboratory expertise and capacity to help monitor community health status and diagnose and investigate public health problems and hazards.
Measure	Written procedures describe how expanded lab capacity is made readily available when needed for outbreak response, and there is a current list of labs having the capacity to analyze specimens.	Has current list of available labs and current written protocols and/or guidelines for handling clinical and environmental laboratory samples.
2. Maintain a competent public health workforce		
	STATE	LOCAL
Standard	Identify the public health workforce (the workforce providing population-based and personal health care services in public and private settings across the state) needs of the state and implement recruitment and retention policies to fill those needs.	Recruit, train, develop, and retain a diverse staff.
Measure	Personnel in regulated professions are assessed to assure that they meet prescribed competencies including certifications, licenses, and education required by law or recommended by local, state, or federal policy guidelines.	Workplace policies promoting diversity and cultural competence, describing methods for compensation decisions, and establishing personnel rules and recruitment and retention of qualified and diverse staff are in place and available to staff.
3. Evaluate and improve programs and interventions		
	STATE	LOCAL
Standard	Evaluate the effectiveness and quality of all programs and activities and use the information to improve performance and health outcomes.	Evaluate the effectiveness and quality of all programs and activities and use the information to improve performance and health outcomes.
Measure	There is a planned, systematic process in which all programs and activities, whether provided directly or contracted, have written goals, objectives, and performance measures. Program performance measures are tracked, the data are analyzed and used to change and improve program activities and services and/or revise curricula/materials.	There is a planned, systematic process in which all programs and activities, whether provided directly or contracted, have written goals, objectives, and performance measures. Program performance measures are tracked, the data are analyzed and used to change and improve program activities and services and/or revise curricula/materials.

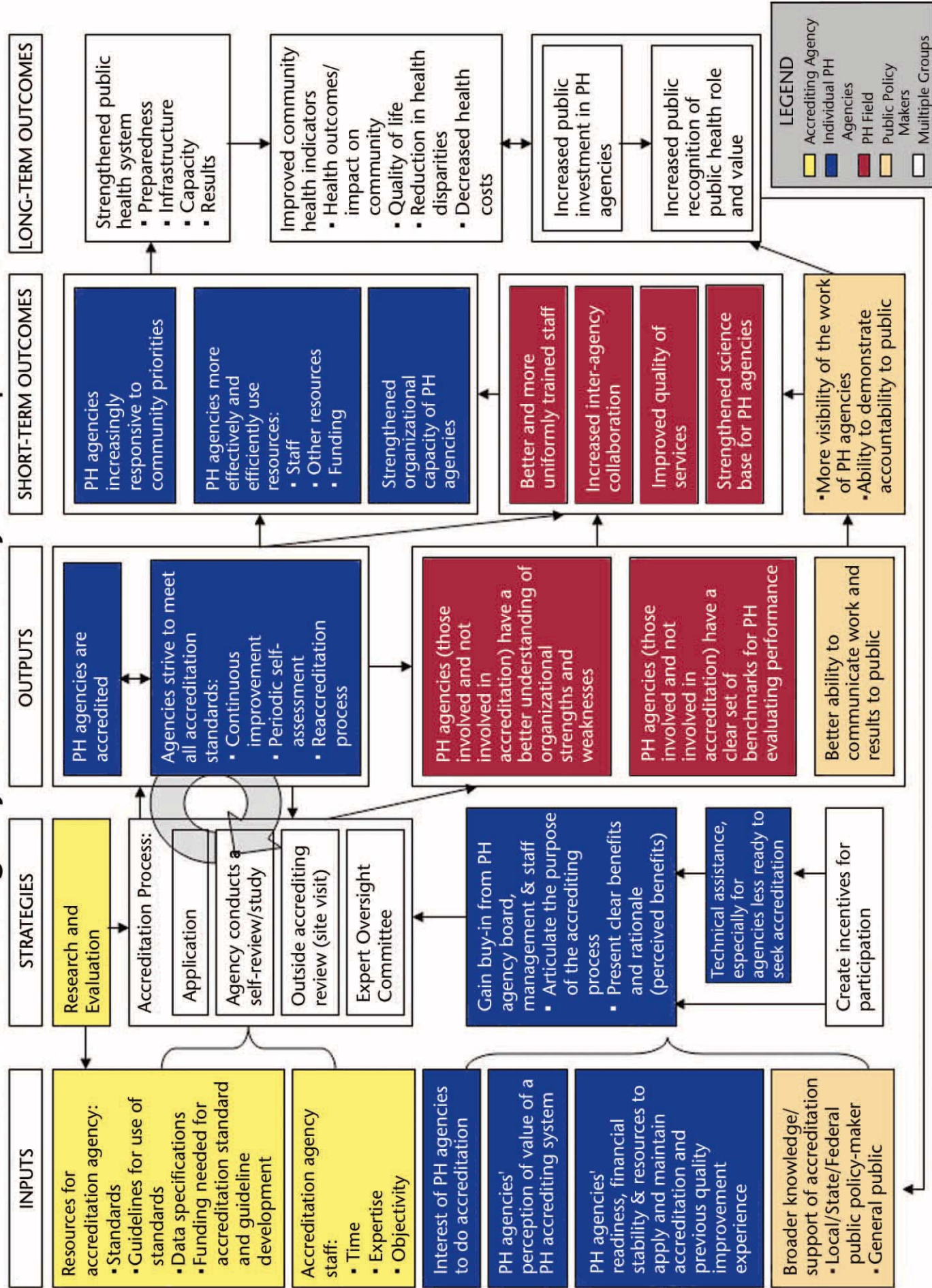
APPENDIX F

LOGIC MODEL

Public Health Agency Accreditation System Implementation (Simplified)

July 21, 2006





APPENDIX G

BUSINESS CASE

TABLE 1: The Market for Accreditation Services

Strata	Population Served LHDs	Number of	Percentage of Total	Estimated Uptake	Number of Applicants
1	0 - 24,999	1322	46.5%	10%	132
2	25,000 - 49,999	579	20.4%	20%	116
3	50,000 - 74,999	261	9.2%	30%	78
4	75,000 - 99,999	139	4.9%	30%	42
5	100,000 - 199,999	235	8.3%	40%	94
6	200,000 - 499,999	177	6.2%	40%	71
7	500,000 - 999,999	69	2.4%	40%	28
8	1,000,000 +	43	1.5%	25%	11
		2825			572
State Health Departments Territories		6		0%	0
Small	500,000 - 4,999,999	31		25%	8
Medium	5,000,000 - 14,999,999	16		25%	4
Large	15,000,000 +	4		25%	1
		57			13
TOTAL HEALTH DEPARTMENTS		2882			585

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

TABLE 2: Cost Components

<p>GOVERNANCE</p> <ul style="list-style-type: none"> Board compensation Number of meetings Committee meetings Sponsors – number and capital v. operations Implementation length (development and pilot testing) Appeals Geography
<p>ADMINISTRATION/MANAGEMENT</p> <ul style="list-style-type: none"> Marketing budget Market size/ penetration over 5 years Size of staff/growth Contractors/outsource Data management Pre-implementation phasing/ number of pilots
<p>STANDARDS AND MEASUREMENTS</p> <ul style="list-style-type: none"> Number and complexity of standards Development process <ul style="list-style-type: none"> • Methods • Interaction with stakeholders • Timeline Revision cycle
<p>CONFORMITY ASSESSMENT</p> <ul style="list-style-type: none"> Cycle length Site visit team size Length of visit Cost and who pays Training site visitors Standardizing Volunteer vs. paid Technical assistance and training for applicants Benchmarking applicant activities Web site development Data collection Self assessment process Vendors “Surveillance” in between surveys

TABLE 3: Potential Sources of Revenue

<p>Applicant fees — These provide a significant source of revenue in most accreditation programs. This empowers applicants to influence operations, standards, and data requirements. At the same time, government budgeting may not provide additional funding for applying for and preparing for accreditation. On the other hand, applicants need a revenue source in order to pay fees. Options include direct grants to applicants, having reimbursements for health department work incorporate the cost of accreditation fees as allowable costs, and including application fees as allowable direct or indirect costs on grants and contracts.</p>
<p>Scholarships/applicant subsidies — These could be direct revenues to the accrediting body or offsets of applicant expenses that allow applicant fees to reflect actual costs.</p>
<p>Grants from government sources — These could be directed to support specific start up activities such as development of standards and conformance processes.</p>
<p>Grants from foundations — These could be directed to support performance improvement strategies in governmental public health agencies, for example.</p>
<p>Service charges — These would underwrite access to data, training services, possibly marketing services, for example.</p>
<p>Capital from traditional sources</p>
<p>Endowments</p>
<p>In-kind/sponsorships — These can offset fixed and capital costs in development and operations, for example and they provide strong messages to the target market about the value of the enterprise.</p>

A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

TABLE 4: The Business Matrix

COST VARIABLE	PREFERRED OPTION	CONSIDERATION
Board composition	Expenses for board meetings only	Stipends send wrong messages. Recruitment of good members likely without them. Not paying expenses increases the reach of the sponsors.
# of board meetings	Initially meet bi-monthly, move to quarterly, with teleconferencing	Initially more expensive but allows the Board itself to do more of the standards and marketing work.
Committee meetings	Few committees Less delegation	
Sponsors # of Contributions Capital Operations (model said no seats)	Seek capitalization of startup and transition. The pool of capital sources is small, and will require showing a plan for sustainability \$\$/\$sponsor	Major concern is finding enough sponsors that capture is not seen as a risk by the potential applicants.
Implementation period to develop accreditation program (develop corporation, standards and processes and conduct one pilot round)	4 years	Should push efficiency and give best chance of finding sponsors. Allows adequate pilot testing. Affects when revenues flow from applicants.
Appeals mechanism	Internal system more control and probably fewer costs	Probably needs to be tested among the potential applicants. Cost are not the only considerations
Geography of headquarters	Seek a balance of costs, access to personnel and academic associations	
Marketing budget	>5% of operating costs, includes developing incentives & subsidies, getting states on board and finding sponsors, TA etc.	In start up, requires maximum effort from board and staff
Market size/ penetration in 5 years of program operation (beyond implementation period)	8-9 (15%) states & 250-400 locals	Signal that this is voluntary, and build credibility
Size/growth of staff	Exec. Dir., Admin. Asst., 2-3 staff with yearly growth to 50% or > of operation costs	
Contract/outsource	Professional consultants, data management and operational functions	Conservative but building a credible organization, not a shell.

TABLE 4: The Business Matrix continued

COST VARIABLE	PREFERRED OPTION	CONSIDERATION
In-kind Fixed Capitalizing	Operational functions, furniture, equipment and space, loaned staff, housed within another organization	Balance is maintaining independence from fostering organization.
Data management	Outsourced initially, move to in-house in operational phase	More expertise needed at front end when resources are thin
Pre-implementation phasing, # of pilots	12 months 3 state pilots 20 local pilots 1 pilot cycle	Assume that accreditation is awarded, but no charge in the pilot cycle
Number and complexity	110 (10 standards per domain)	The number of standards affects many costs. There is a multiplier effect for an accrediting entity and for applicants.
Methods for developing standards and measures	Committee process to integrate existing models and seek input	Balancing broad participation and recognizing existing innovations
Interactions and Timeline	Active input process: 12 - 18 months	Balancing full input and stakeholder buy-in with time
Revision cycle is crucial.	Every 5 years, with triggers for interim changes	Credibility of standards
Cycle length	4 years	Balancing frequency with costs, especially in early years.
Site visit team size	3 – 5, varying with size and complexity of applicant	Use more days instead of more people, but try to keep to <2 days
Length of visit	1 day	The composition of teams and length of visits are determined by the scope and complexity of the standards
Costs/payers	Fee + site visit expenses using a mix of volunteer & paid surveyors Applicant pays, accreditation pays paid surveyors	Stable and predictable assessment process
Training volunteer site visitors	In-person training (1 day) with web back-up	Stable and predictable assessment process

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TABLE 4: The Business Matrix continued

COST VARIABLE	PREFERRED OPTION	CONSIDERATION
Standardizing site visitor work	Training site visit, group discussions, look back, or matched scoring	Stable and predictable assessment process
Volunteer/paid	Team leader only paid, others volunteer	Stable and predictable assessment process
Technical assistance for applicants	Offer on-line and telephone TA	Stable and predictable assessment process
Benchmarking of compliance strategies	Offer on-line information and written materials	
Web site development Maintenance	All on-line, electronic exchange	Important trade off of agency costs with applicant efficiency
Data collection	Needed for decisions and accredited body programs operations evaluation	
Self-assessment process	More detailed internally -onsite validation -selective	Learn efficiencies from current assessment programs
Vendors	Existing state programs only	Manageable -negotiation -controls -risk management
Surveillance between site visits	Annual report -update -compliance -changes	Consider moving to selective audits or revisits as program matures

TABLE 5

	YEAR 1 Development	YEAR 2 Development	YEAR 3 Development	YEAR 4 Operations	YEAR 5 Operations	YEAR 6 Operations	YEAR 7 Operations	YEAR 8 Operations
Total Salary and Fringe	\$270,000	\$283,500	\$297,675	\$320,892	\$402,938	\$456,785	\$479,473	\$494,950
Total Direct Expenses	\$564,000	\$383,000	\$459,200	\$696,400	\$765,200	\$789,520	\$894,150	\$904,600
TOTAL EXPENSES	\$834,000	\$666,500	\$756,875	\$1,017,292	\$1,168,138	\$1,246,305	\$1,373,623	\$1,399,550
Total Revenues	\$0	\$80,000	\$120,000	\$565,000	\$905,000	\$940,000	\$1,505,000	\$1,505,000
NET INCOME	-\$834,000	-\$586,500	-\$636,875	-\$452,292	-\$263,138	-\$306,305	\$131,377	\$105,450

*Red font distinguishes the development period from the operational period.

APPENDIX H

GLOSSARY

GLOSSARY

Accreditation – (1) the development of a set of standards, a process to measure health department performance against those standards, and some form of reward or recognition for those agencies meeting the standards. (2) the periodic issuance of credentials or endorsements to organizations that meet a specified set of performance standards. (3) A voluntary conformity assessment process where an organization or agency uses experts in a particular field of interest or discipline to define standards of acceptable operation/performance for organizations and measure compliance with them. This recognition is time-limited and usually granted by nongovernmental organizations.

1 – EA project definition

2 – Lee Thielen

3 – Michael Hamm

Accountability – the principle that individuals, organizations and the community are responsible for their actions and may be required to explain them to others.

Benchmark – a standard established for anticipated results, often reflecting an aim to improve over current levels.

Beta testing (pilot testing) – allowing organizations to use a new product before it is officially launched.

Capacity – resources and relationships necessary to carry out the core functions and essential services of public health; these include human resources, information resources, fiscal and physical resources, and appropriate relationships among the system components.

– Bernard Turnock, *Public Health: What It Is and How It Works*

Conformity assessment – the determination of whether a product, process, or service conforms to particular standards or specifications. Activities associated with conformity assessment may include testing, certification, accreditation, and quality assurance system regulation.

– Michael Hamm

Conditional accreditation – a rating that an organization receives when a number of standards were scored 'not compliant' at the time of the onsite survey.

– Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Continuous quality improvement – an ongoing effort to increase an agency's approach to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured as part of accreditation.

– Public Health Foundation (PHF)

Core standards – the fundamental activities or group of activities, so critical to an organization's success that failure to perform them in an exemplary manner will result in deterioration of the organization's mission.

Customer – the person or group that establishes the requirement of a process and receives or uses the outputs of that process, or the person or entity directly served by the organization.

– *Serving the American Public: Best Practices in Performance Measurement*

Domain – a broad area having some common characteristics and for which criteria and standards are specified for assessing performance in that domain.

–Michael Hamm

Evaluation - Systematic approach to determine whether stated objectives are being met.

–Brownson, RC, Baker EA, and Novick, LF. *Community-based Prevention: Programs That Work*. Gaithersburg, MD: Aspen Publishers, Inc. 1999

Impact – the total, direct and indirect, effects of a program, service or institution on a health status and overall health and socio-economic development.

Measure – a statement of quantification/qualification/ action to reach a desired condition/state of affairs; the means of determining compliance with a standard.

Example: The number of trained epidemiologists available to investigate outbreaks (capacity measure).

Example: The percentage of notifiable diseases reports submitted within the required time lines (process measure).

Example: Percentage of disease outbreaks that are controlled and contained before deaths or disabling conditions occur (outcome measure).

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Outcome – (1) the desired result of a service or program; (2) indicator of health status, risk reduction, and quality-of-life enhancement. For the purposes of the Exploring Accreditation project, short-term outcomes are defined as results that are achieved in 1 year; results of intermediate outcomes are achieved between 2-5 years; and results of long-term outcomes are achieved between 5-10 years.

– (2) *Bernard Turnock, Public Health: What It Is and How It Works*

Performance standard – a generally accepted, objective form of measurement that serves as a rule or guideline against which an organization’s level of performance can be compared.

– *Guidebook for Performance Measures Turning Point Program*

Performance improvement/

Quality improvement – Systematic processes of designing and developing cost-effective and ethically-justifiable methods to address performance gaps or improve products; implementing processes, procedures, and/or interventions in order to obtain better results; and/or evaluate financial and non-financial findings in order to improve efficiency in obtaining results. Quality improvement contains the element of “doing the right thing” while performance improvement is focused on doing what we are doing “better.”

– *From Silos to Systems Turning Point Program*

Research - A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.

-*United States Department of Health and Human Services. Healthy People 2010. Washington, DC: US Department of Health and Human Services, 2000*

Standard – a desired condition/state of affairs, and must be actionable, attainable, and measurable.

APPENDIX I

PUBLIC COMMENT TABLES

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TABLE 1. Number of Respondents by Affiliation

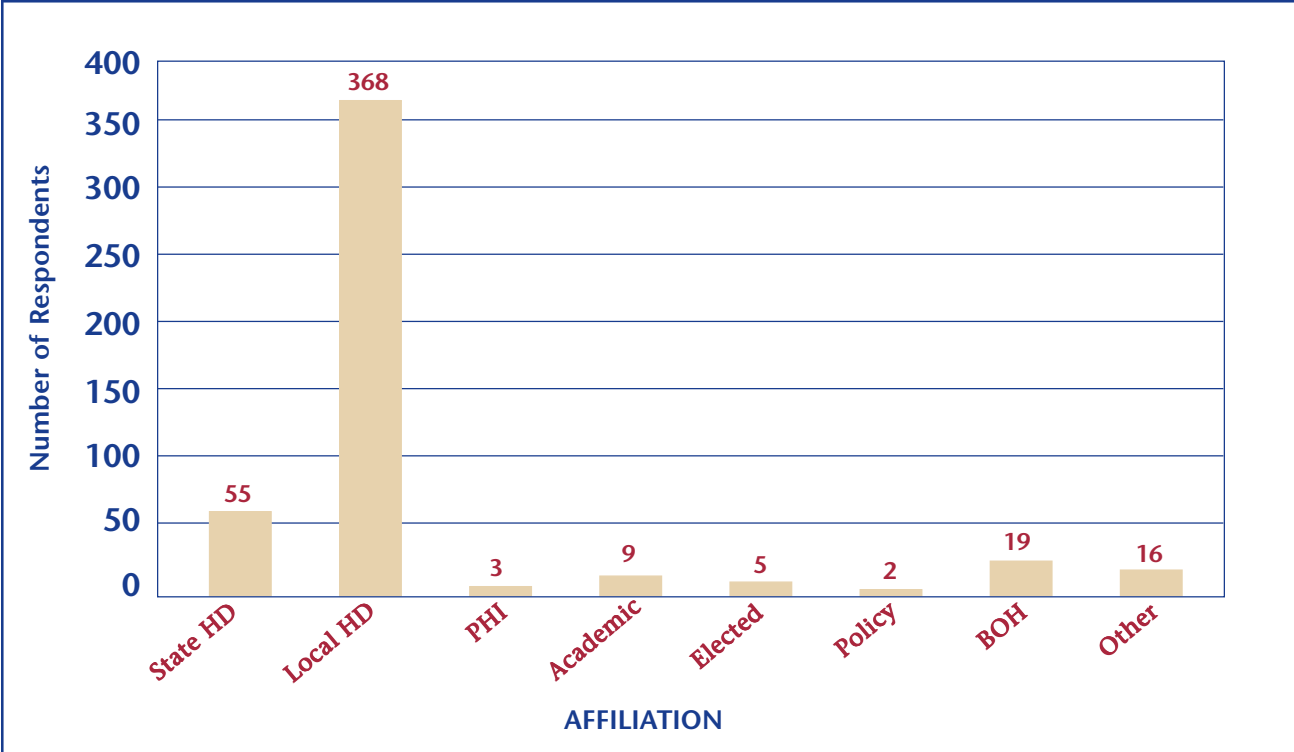


TABLE 2. Number of Respondents by U.S. Public Health Service Region

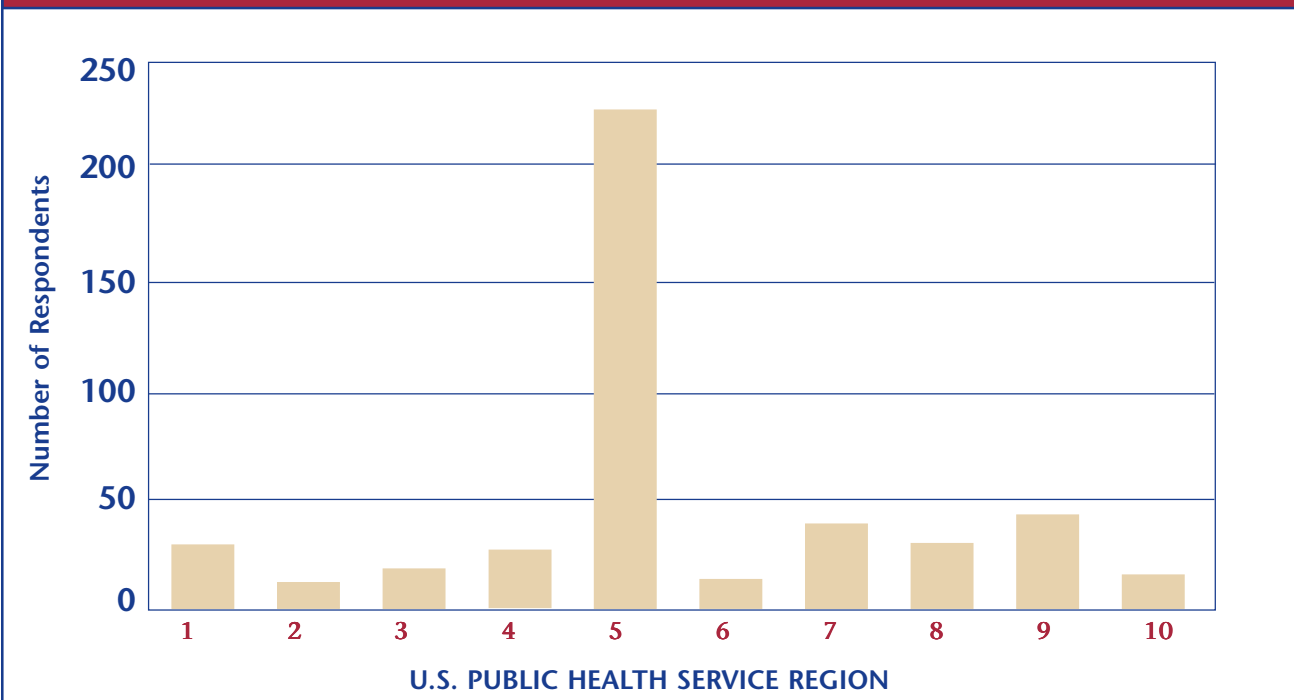


TABLE 3. Number of Respondents by Size of Jurisdiction

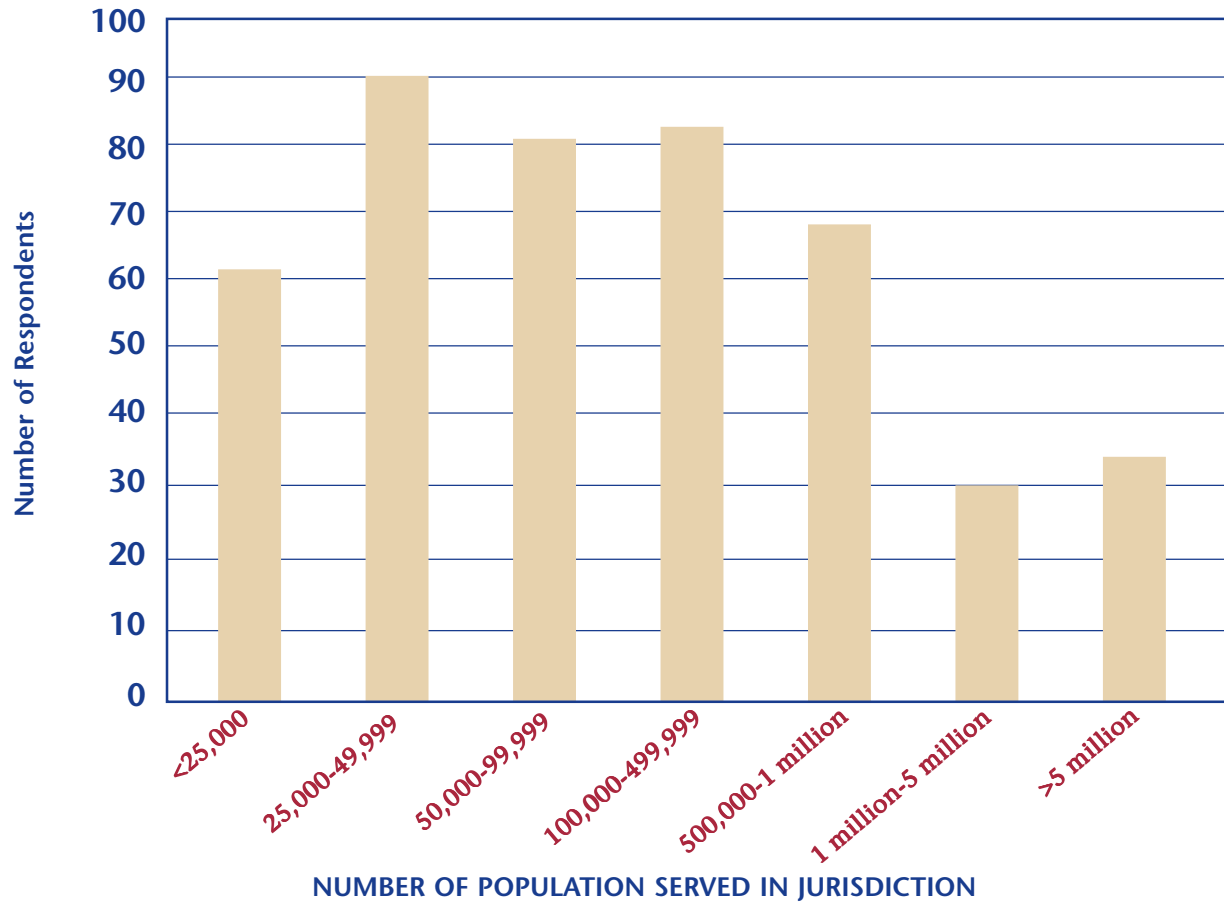
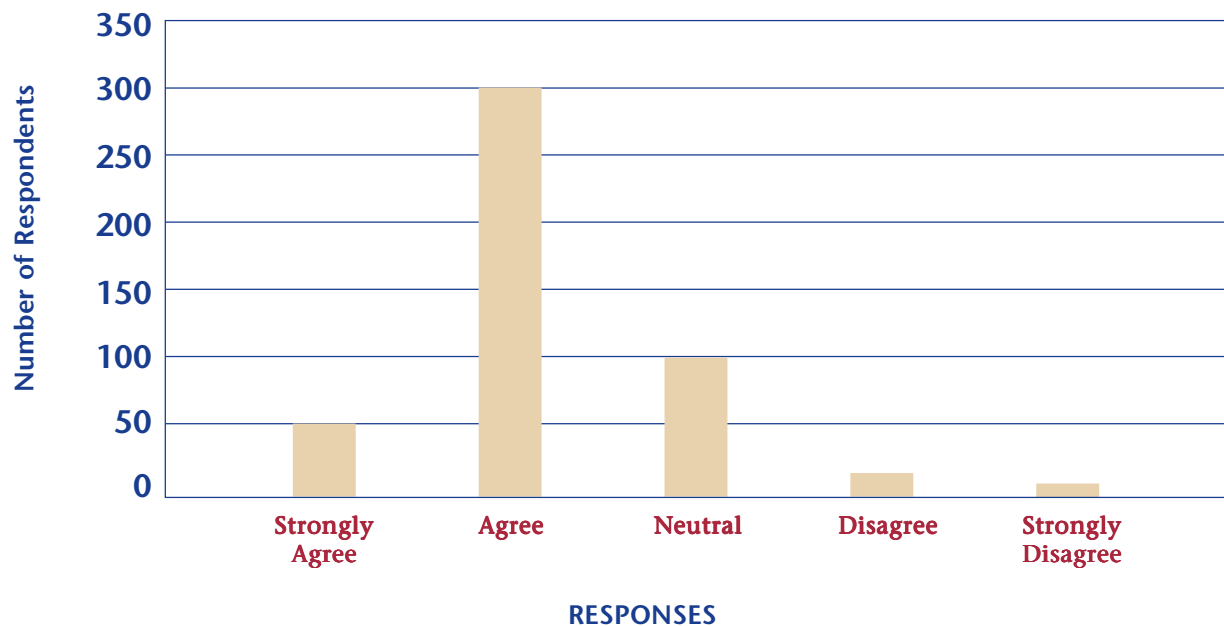


TABLE 4. The Model is Understandable (All Responses)



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TABLE 5. The Model is Feasible for Implementation (All Responses)

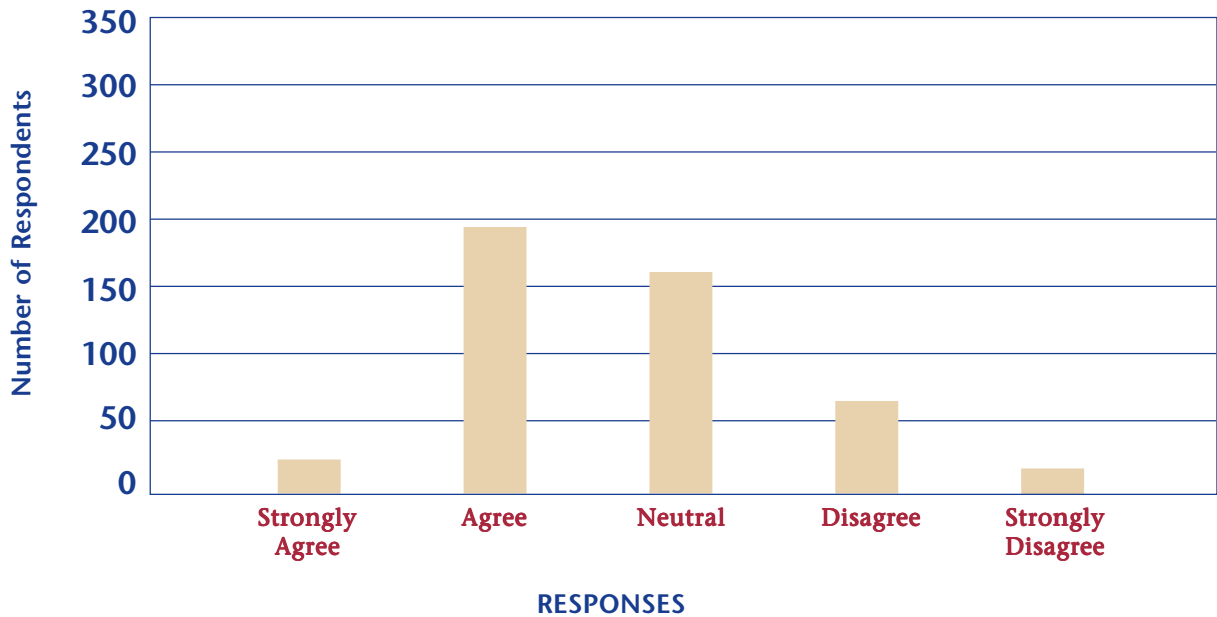


TABLE 6. Our Health Department Would Seek Accreditation Under this Model (All Responses)

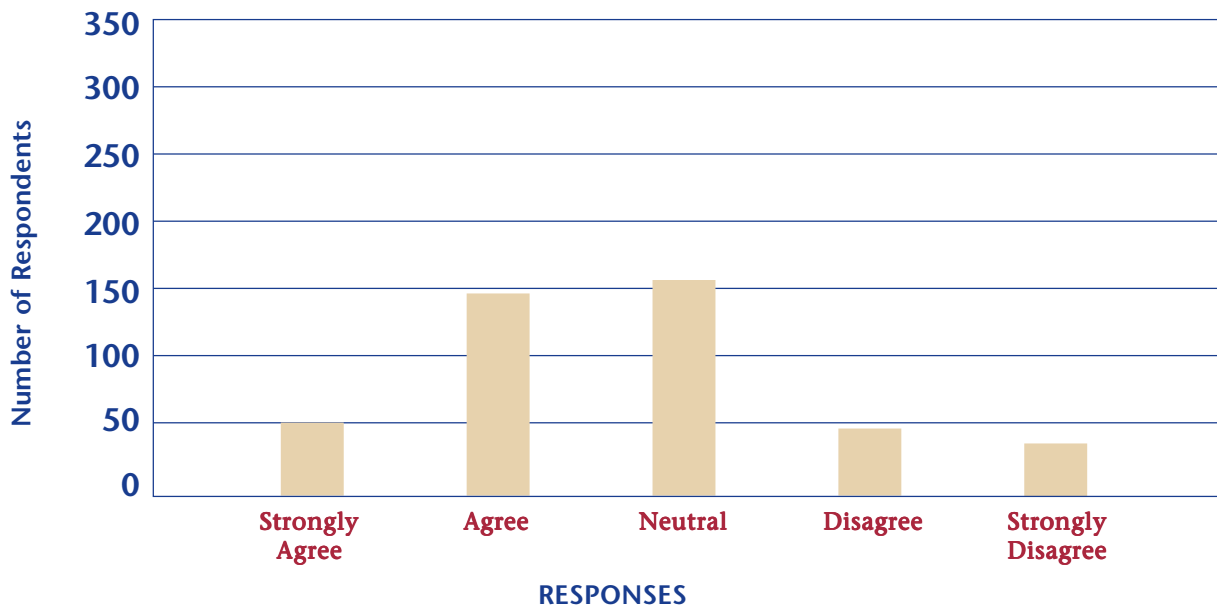


TABLE 7. The Model is Understandable (State and Local Health Department Responses)

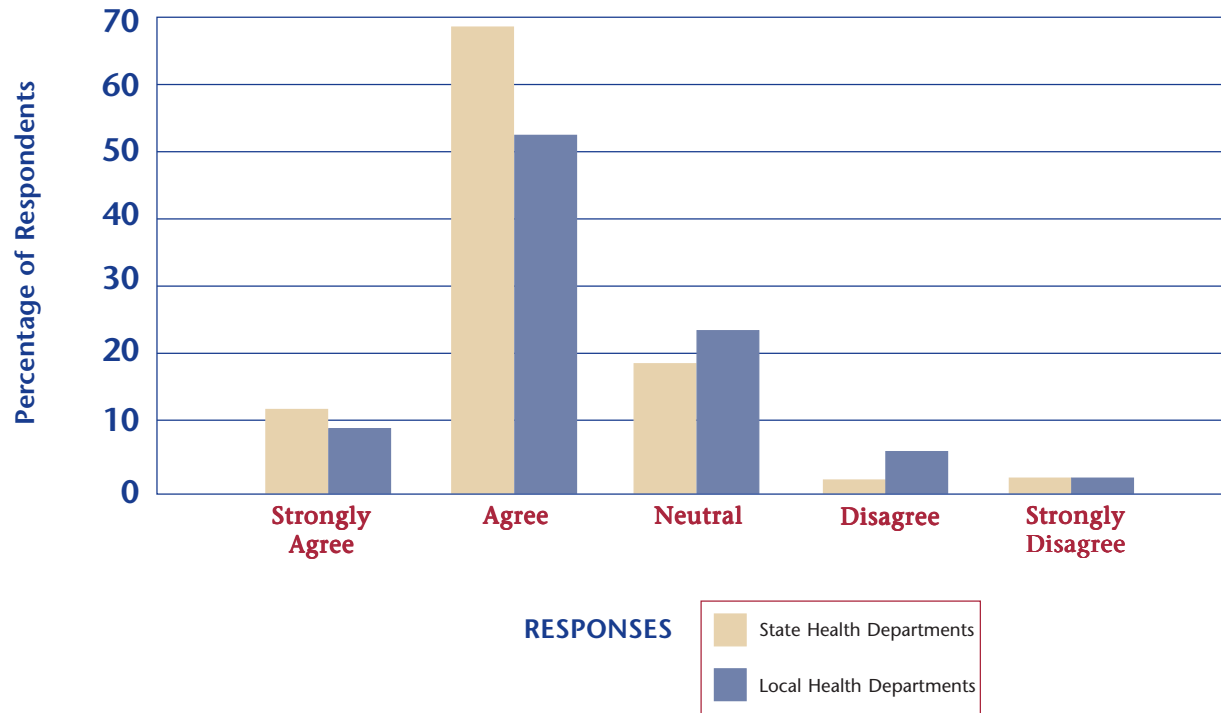
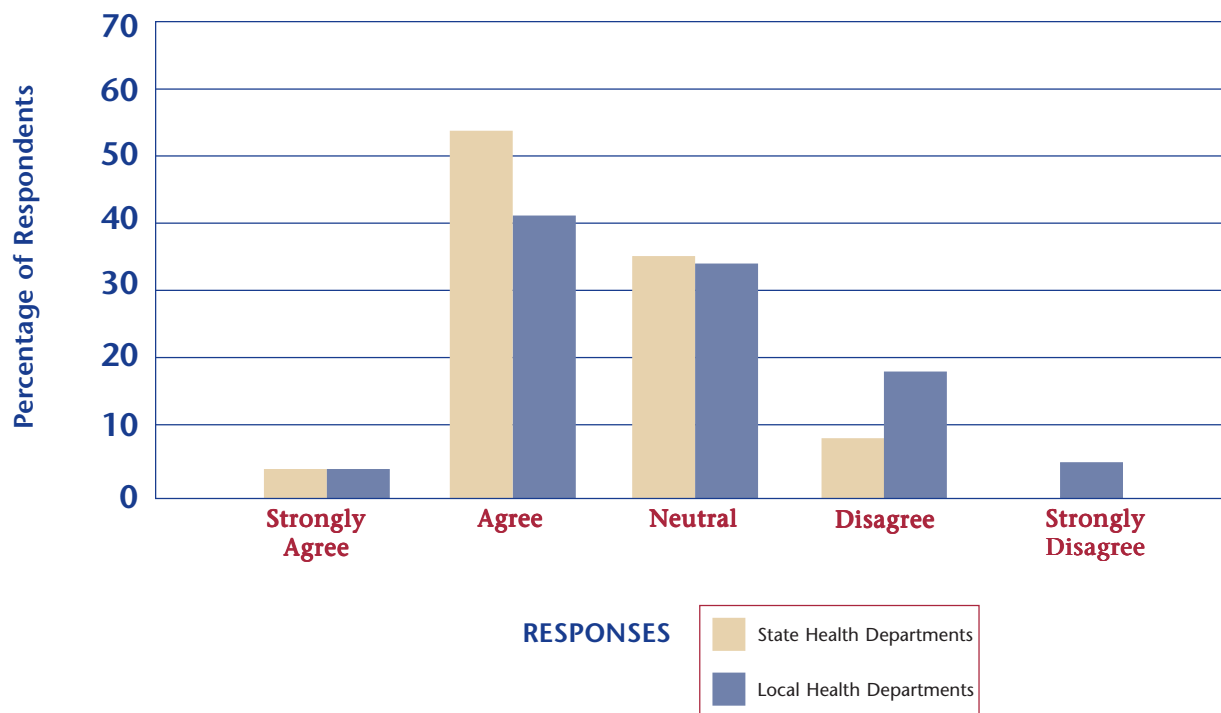


TABLE 8. The Model is Feasible for Implementation (State and Local Health Department Responses)



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TABLE 9. Our Health Department Would Seek Accreditation Under this Model (State and Local Health Department Responses)

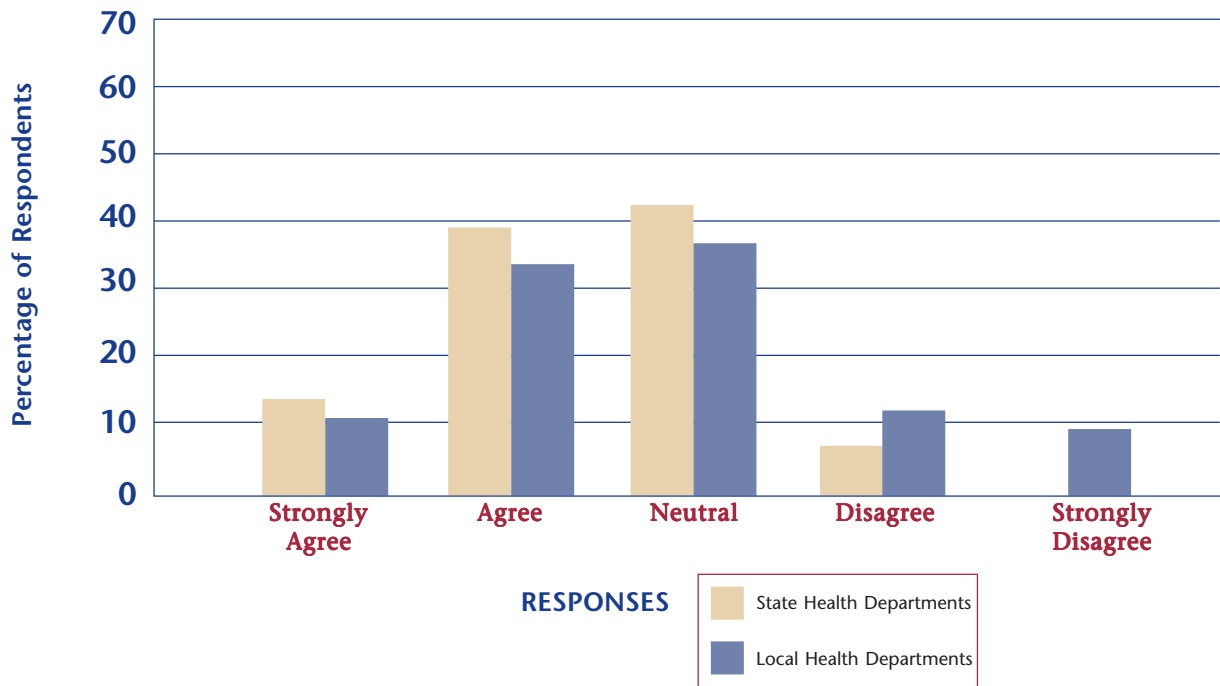


TABLE 10. Our Health Department Would Seek Accreditation Under this Model (By Size of Health Department)

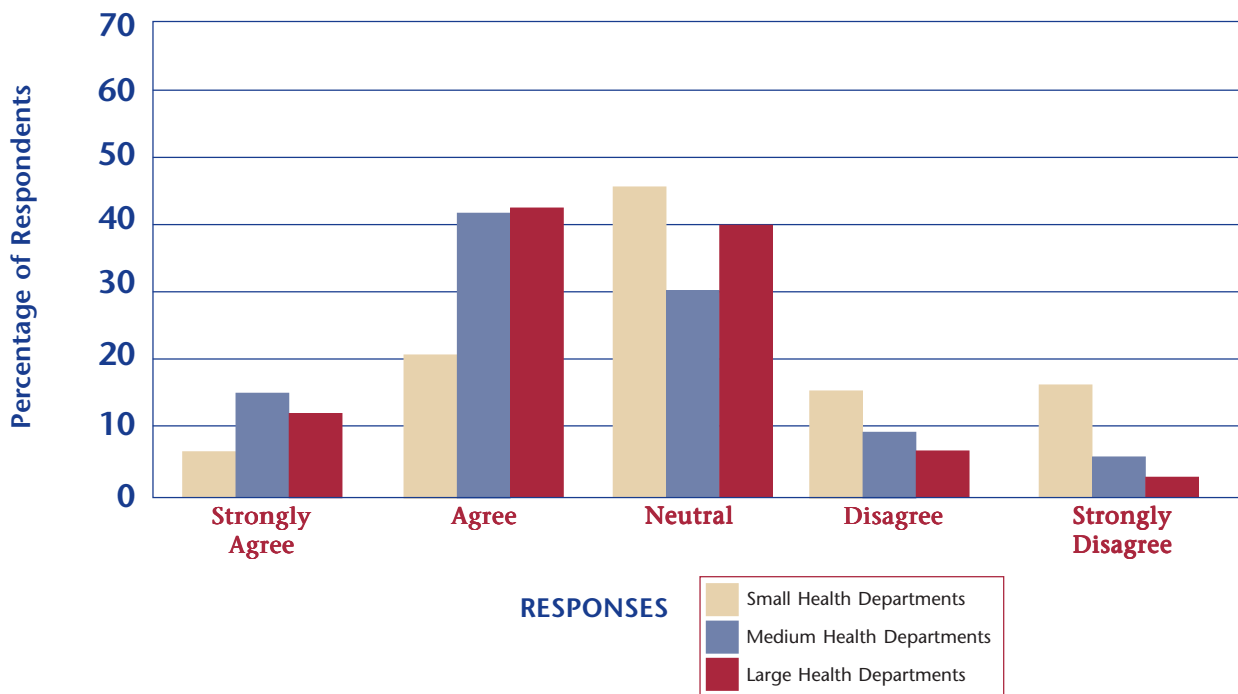


TABLE 11. What Benefits of Accreditation are Most Important in Your Thinking About Accreditation (All Responses)

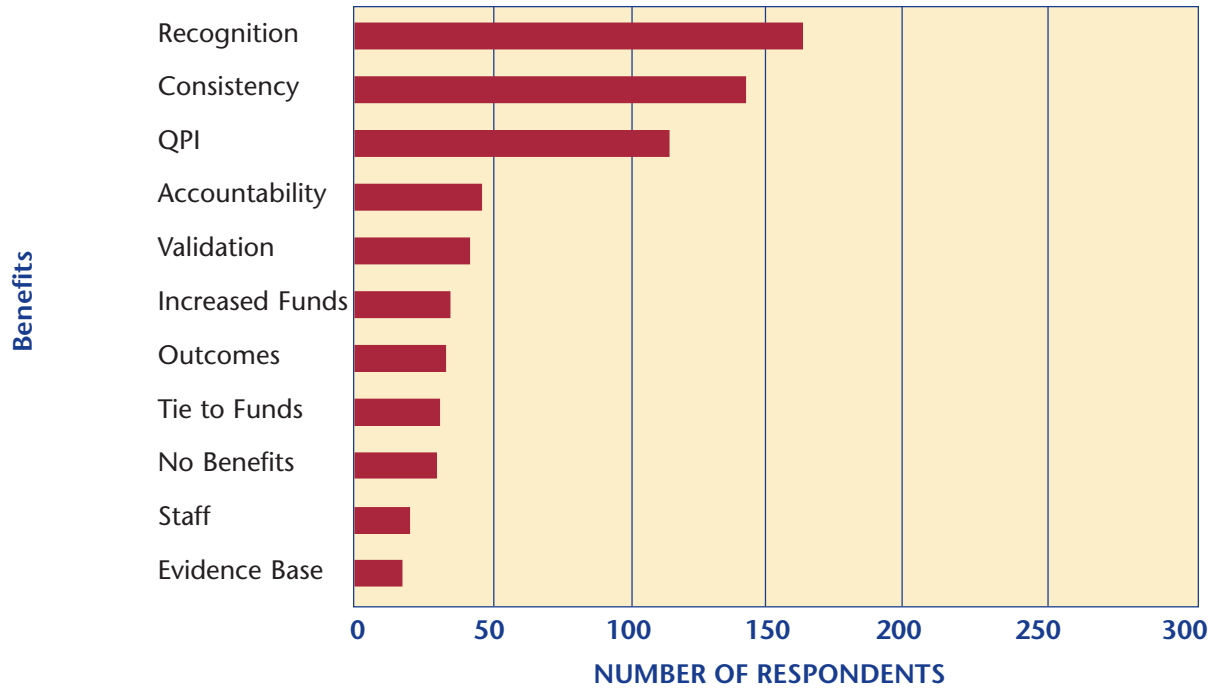
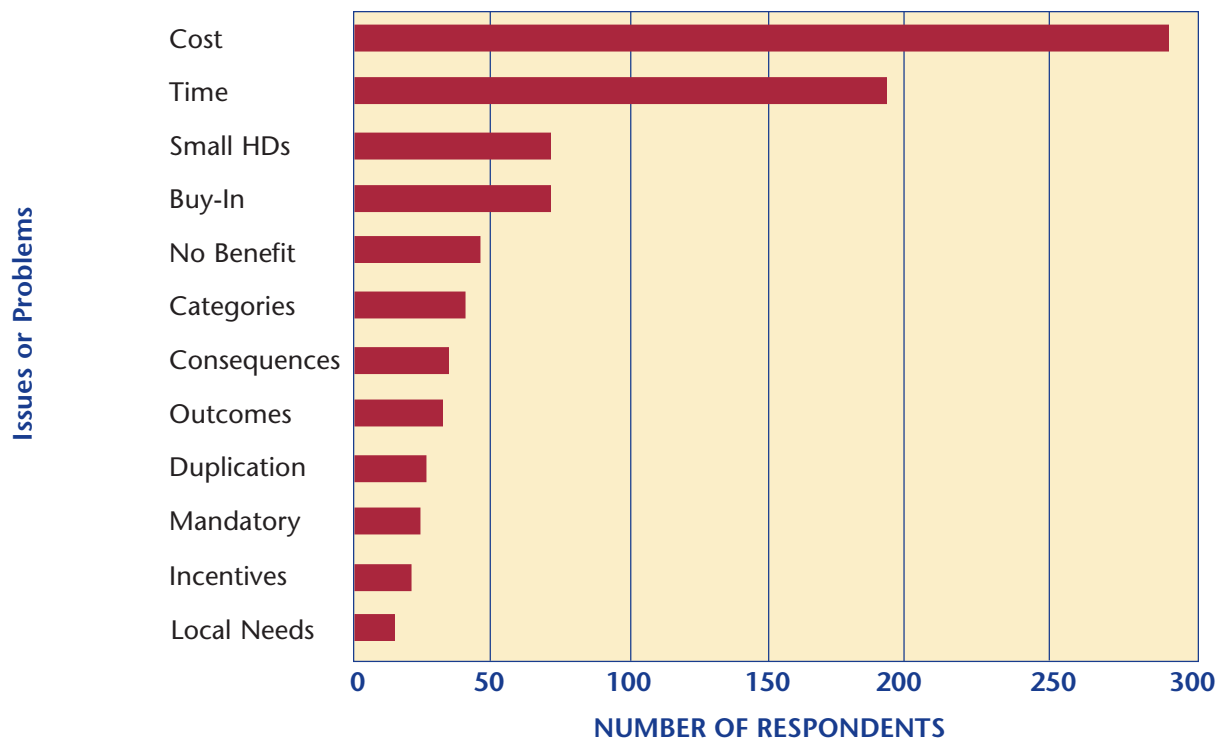
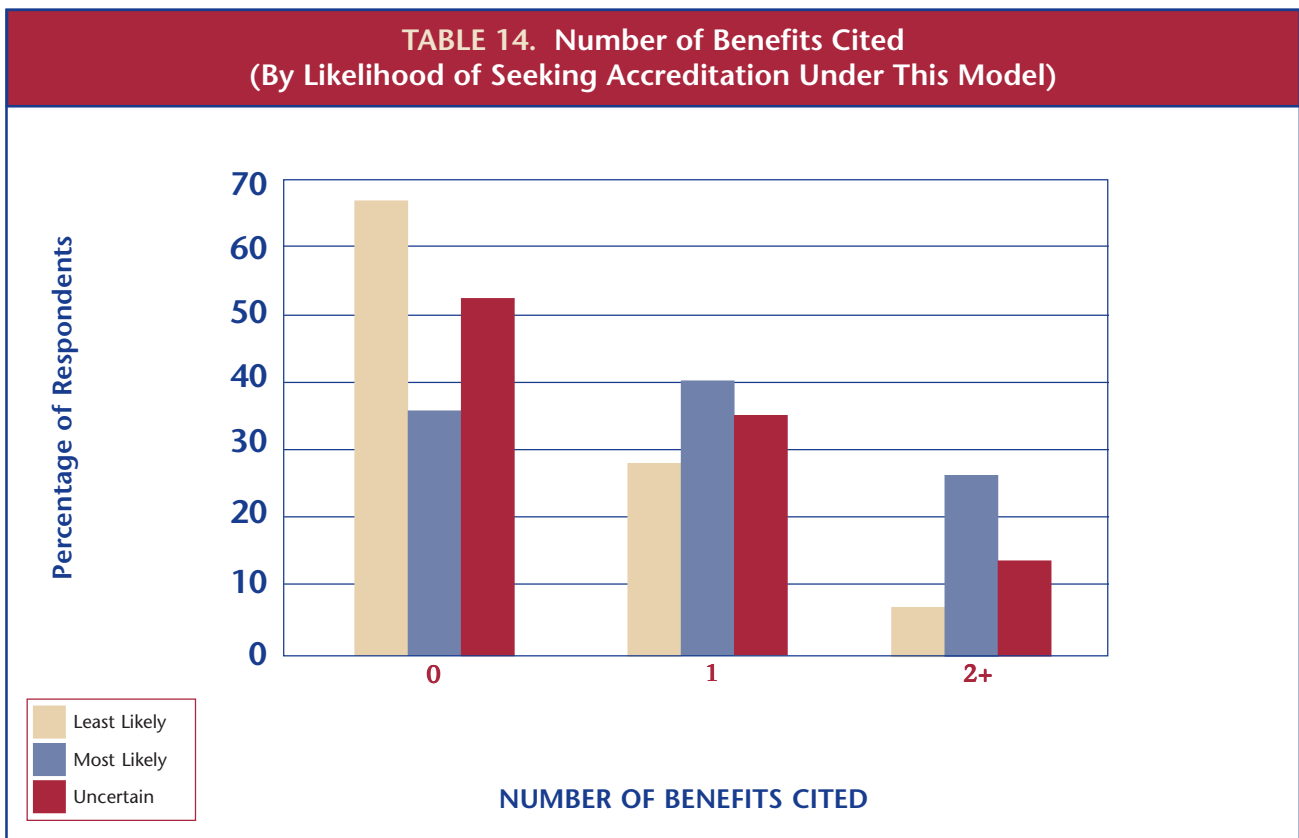
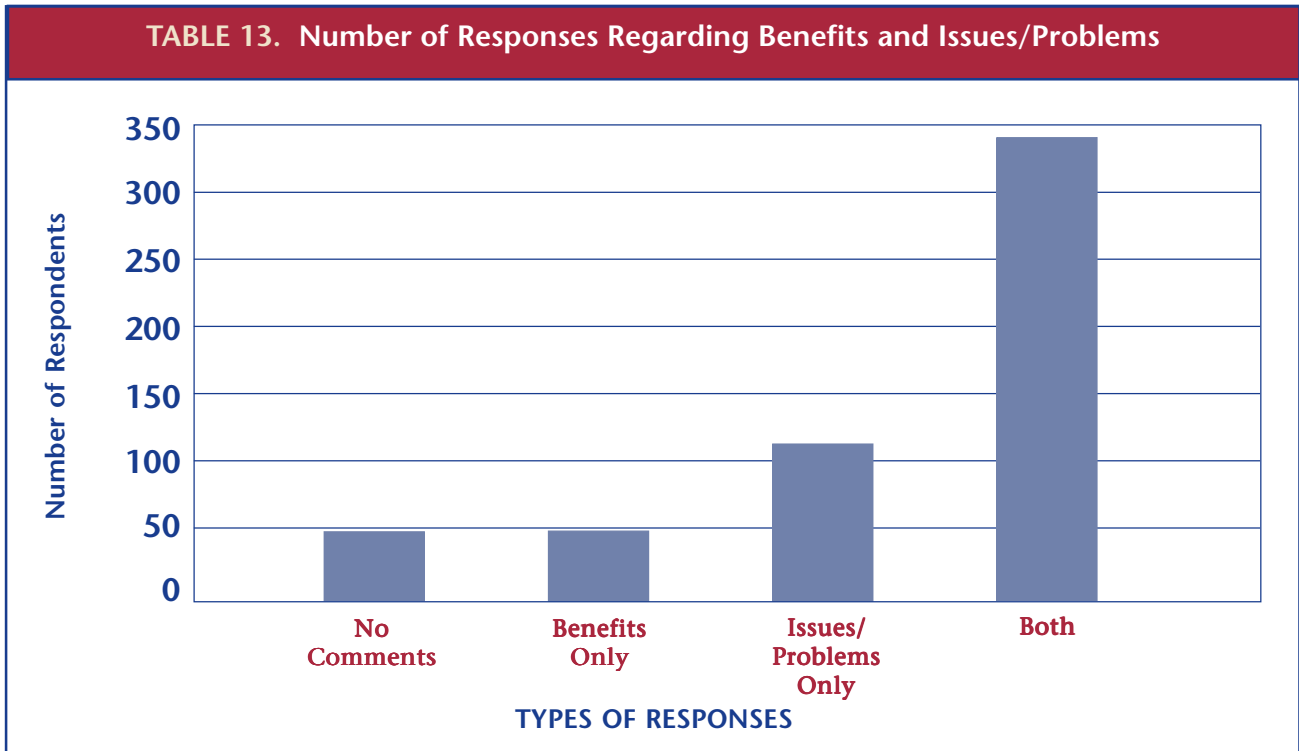


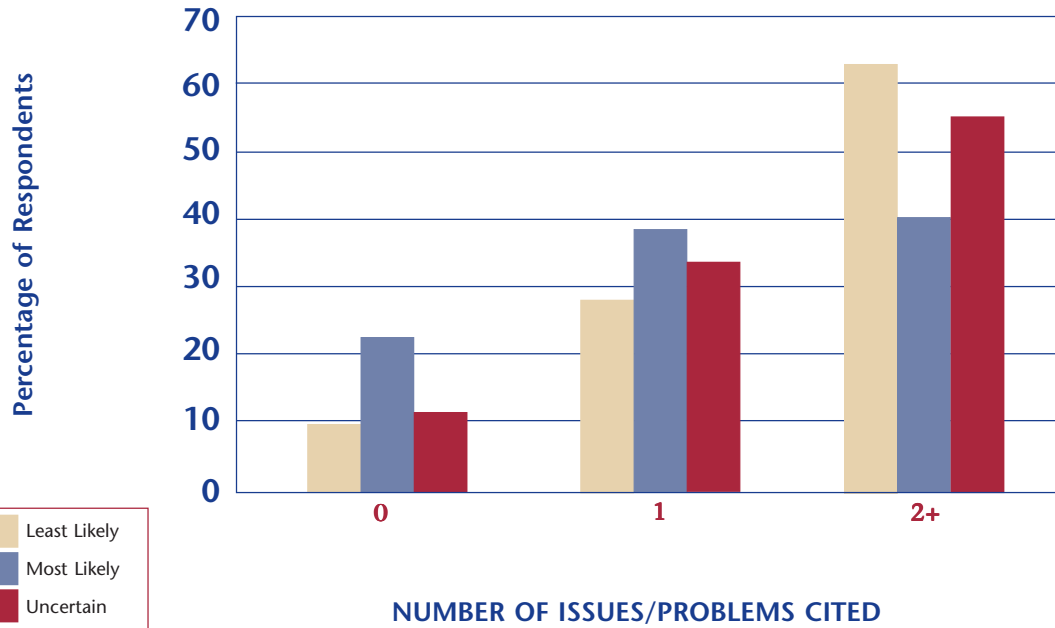
TABLE 12. What Issues or Problems are Most Likely to Result in Your Deciding Against Supporting Accreditation (All Responses)



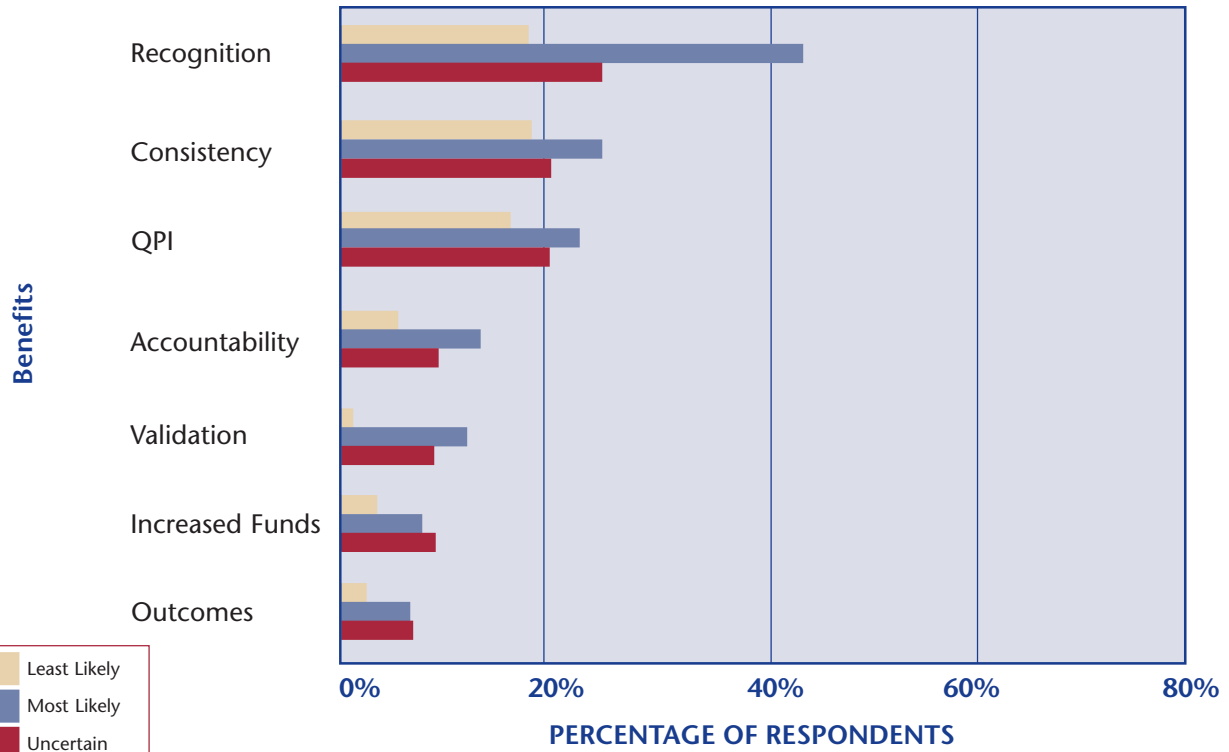
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**TABLE 15. Number of Issues/Problems Cited
(By Likelihood of Seeking Accreditation Under This Model)**

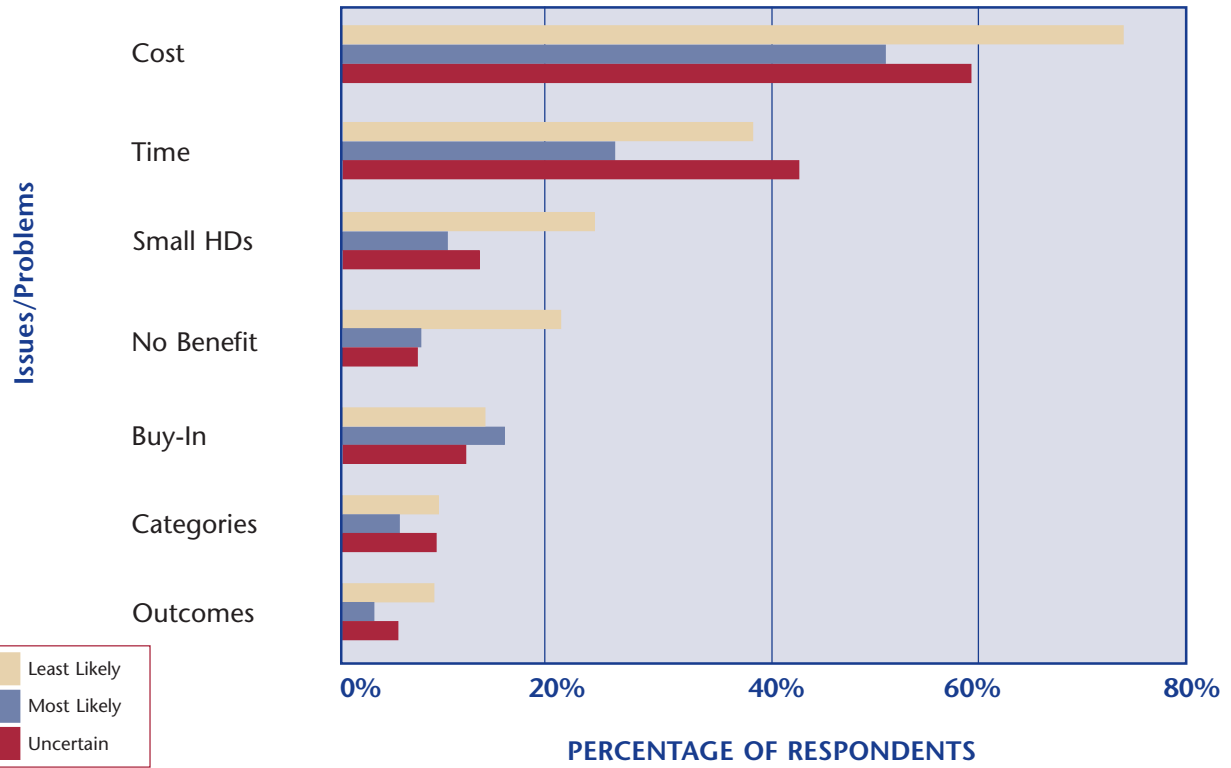


**TABLE 16. What Benefits of Accreditation are Most Important in
Your Thinking About Supporting Accreditation
(By Likelihood of Seeking Accreditation Under This Model)**



A VOLUNTARY NATIONAL ACCREDITATION PROGRAM FOR STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS

**TABLE 17. What Issues or Problems are Most Likely to Result in Your
Deciding Against Supporting Accreditation
(By Likelihood of Seeking Accreditation Under This Model)**



WWW.EXPLORINGACCREDITATION.ORG



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