

VERSION 2.0 WORK IN PROGRESS: Chronic Disease – What Have We Learned from Accredited Health Departments? February 2020



The Public Health Accreditation Board is a 501(c)3 nonprofit organization dedicated to improving and protecting the health of the public by advancing and ultimately transforming the quality and performance of state, local, tribal, and territorial public health departments.



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This document summarizes what PHAB has learned about how health departments (HDs) participating in accreditation are addressing chronic disease-related activities. In particular, it focuses on the reasons that HDs struggled with measures that relate to chronic disease. It is important to note that these measures were selected because they are relevant to chronic disease (e.g., they might require that one of the examples relate to a chronic disease program). However, they are broader than chronic disease. Therefore, health departments may have been assessed as Slightly or Not Demonstrated (SD/ND) on these measures for reasons unrelated to their chronic disease programming.

It also includes findings from an analysis of accredited health departments' community health improvement plans (CHIP) and a list of population health outcomes health departments are tracking in their communities.

Below is a summary of the distribution of assessments for related measures. These data are for 179 HDs assessed under Version 1.0 and 158 HDs assessed under Version 1.5 of the Standards & Measures.

Measure	%Fully Demonstrated	%Largely Demonstrated	%Slightly Demonstrated	%Not Demonstrated	N
1.1.2 (ver 1.0)	43.6%	49.2%	7.3%	0.0%	179
1.1.2 (ver 1.5)	12.0%	61.4%	26.6%	0.0%	158
2.1.1	68.2%	23.1%	7.4%	1.2%	337
2.1.3	89.3%	5.0%	3.0%	2.7%	337
3.1.1	46.0%	41.5%	12.2%	0.3%	337
3.1.2 (ver 1.0)	54.7%	31.8%	11.2%	2.2%	179
3.1.2 (ver 1.5)	28.5%	51.3%	19.6%	0.6%	158
3.1.3 (ver 1.5)	39.2%	37.3%	21.5%	1.9%	158
3.2.3 (3.2.2 in ver 1.0)	48.1%	41.2%	9.8%	0.9%	337
3.2.5 (3.2.4 in ver 1.0)	80.7%	18.1%	1.2%	0.0%	337
3.2.5 (ver 1.0, similar to 3.2.6 in ver 2.0)	69.3%	28.5%	1.7%	0.6%	179
3.2.6 (ver 1.5)	62.0%	35.4%	2.5%	0.0%	158
4.1.1 (ver 1.0)	86.6%	11.2%	2.2%	0.0%	179
4.1.1 (ver 1.5)	44.3%	52.5%	2.5%	0.6%	158
5.2.2 (ver 1.0)	51.4%	37.4%	11.2%	0.0%	179
5.2.2 (ver 1.5)	31.0%	53.2%	14.6%	1.3%	158
7.1.1 (ver 1.0)	69.8%	20.7%	7.8%	1.7%	179
7.1.1 (ver 1.5)	29.7%	42.4%	26.6%	1.3%	158
7.1.3 (ver 1.0)	53.1%	27.9%	19.0%	0.0%	179
7.1.3 (ver 1.5)	33.5%	35.4%	29.1%	1.9%	158
10.1.1	74.5%	17.5%	5.6%	2.4%	337
11.1.3 (ver 1.0, similar to 11.1.4 in ver 1.5)	53.6%	40.8%	5.6%	0.0%	179
11.1.4 (ver 1.5)	45.6%	48.7%	5.1%	0.6%	158

Data are presented separately for health departments assessed under Version 1.0 and Version 1.5 of the Standards & Measures if there was a substantive change in the requirements. If the two versions are

substantively the same, the aggregate data are presented. The numbering of some of the measures changed between Version 1.0 and Version 1.5. (For example, the measure about the communication procedures plan was 3.2.2 in Version 1.0 and 3.2.3 in Version 1.5.)

To better understand HDs' performance on these measures, PHAB conducted an analysis of the conformity comments of HDs that were assessed as Slightly or Not Demonstrated (SD/ND) in at least 5% of the Site Visit Reports. The results of those analyses are shown below. For each measure, the most common reasons for the assessment are listed, including the number of HDs for which that reason was indicated. One HD could have multiple reasons listed. The reasons are linked to specific required documentation (RD) listed in the PHAB Standards & Measures. For reference, please see: https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf.

Measure 1.1.2: A state/Tribal/local community health assessment

Of the 55 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD 2: Opportunity for community to provide input into assessment (44 HDs)
- RD 2: Sharing of preliminary findings with community (32 HDs)
- RD 1: Discussion of inequities/disparities* (28 HDs)
- RD 1: Consideration of factors that contribute to higher health risks and poorer health outcomes in specific populations* (25 HDs)
- RD 1: Description of community assets (20 HDs)
- Complete date within the time period (17 HDs)
- RD 3: Neighborhood/community specific analysis* (13 HDs)
- RD 1: Outcomes in specific populations* (12 HDs)
- RD 3: Ongoing monitoring* (12 HDs)
- RD 1: Adequate description of the demographics of the population (11 HDs)
- RD 3: Engagement/link to community identified in CHA as part of ongoing monitoring* (11 HDs)
- RD 1: Description/distribution (10 HDs)

* Added in Ver 1.5

Measure 2.1.1: Protocols for investigation process

Of the 29 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1b: Protocol steps that include timelines (13 HDs)
- RD1a: Assignment of responsibilities (11 HDs)
- Date that meets measure requirements (10 HDs)
- RD1b: Protocol that includes investigation steps (10 HDs)
- Protocol that comprehensively covers diseases and environmental health issues (8 HDs)
- RD1b: Protocol that includes reporting requirements (8 HDs)

Measure 2.1.3: Capacity to conduct investigations of non-infectious health problems, environmental, and/or occupational public health hazards

Of the 19 HDs assessed as SD/ND, the most common challenges with documentation were:

- Documentation was not about investigation of a hazard (11 HDs)
- Insufficient evidence of HD's role (5 HDs)

Measure 3.1.1: Information provided to the public on protecting their health

Of the 42 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD2: Consultation with community & target group in developing materials (30 HDs)
- RD3: Messages coordinated with other HDs or community partners (21 HDs)
- RD1: Cultural competence & health literacy taken into account (18 HDs)
- RD1: Distribution of the information (13 HDs)
- RD2: Social and environmental factors addressed (13 HDs)
- RD1: Indication of target audience (12 HDs)
- RD2: Community and target group involvement for the purpose of developing the messages and materials (11 HDs)

Measure 3.1.2: Health promotion strategies to mitigate preventable health conditions

Of the 56 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD3: Solicitation of review, input, and/or feedback from the target audience during the development of the health promotion strategy (40 HDs)
- RD4: Collaboration with partners in implementing strategy (36 HDs)
- RD2: Use of various marketing or change methods (30 HDs)
- RD2: Strategies are evidence-based, rooted in sound theory, practice-based evidence, and/or promising practice (24 HDs)
- RD2: Engagement of community and target audience in development of strategy (21 HDs)
- RD2: Strategy includes a focus on social and environmental factors (16 HDs)
- Articulation of a strategy throughout the documentation (14 HDs)
- RD2: Planned collaborative implementation (13 HDs)
- RD3: Consistent use of program examples across RDs (12 HDs)
- RD1: Planned approach for developing health promotion programs (11 HDs)
- Evidence of implementation (11 HDs)
- Priorities identified through health improvement plan (requirement in Ver 1.0 of S&M only) (10 HDs)

Measure 3.1.3: Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes (Measure added in Version 1.5)

Of the 37 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- Element c: Internal policies and procedures to ensure programs address specific populations (22 HDs)
- Element b: Plans/efforts to address social change, social customs, community policy, level of community resilience or the community environment (17 HDs)
- Element a: Analysis of factors that cause or contribute to health equity (12 HDs)
- Element a: Analysis of health equity (11 HDs)

Measure 3.2.3: Communication procedures to provide information outside the health department (3.2.2 in Version 1.0)

Of the 36 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1: Dissemination of accurate, timely, appropriate information for different audiences (25 HDs)
- RD1: Coordination with community partners for communicating messages (18 HDs)
- RD1: Description of responsibility of staff positions that interact with news media and public (16 HDs)
- RD2: Implementation of communications procedures (13 HDs)
- RD1: Indication of when contact list used and how maintained (12 HDs)
- RD1: Contact list of media/key stakeholders (11 HDs)

Measure 5.2.2: State/Tribal/local health improvement plan adopted as a result of the health improvement planning process

Of the 45 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1d: Alignment w/state, national, or local priorities (30 HDs)
- RD1b: Policy changes needed to accomplish health objectives (in ver 1.5 these must address inequities) (27 HDs)
- RD1a: Measurable outcomes or indicators of health improvement (in ver 1.0 this was RD1d) (22 HDs)
- RD1c: Specific designation of individuals and organizations that have accepted responsibility for implementing strategies (20 HDs)
- RD1a: Time-framed targets (17 HDs)
- RD1a: Consideration of social determinants of health (added in ver 1.5) (14 HDs)
- RD1a: Address inequities (added in ver 1.5) (11 HDs)

Measure 7.1.1: Process to assess the availability of health care service

Of the 61 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD2: Data shared for the purposes of assessing the availability of health care services and for planning (23 HDs)
- RD1: Collaborative process relates to access of care (21 HDs)
- RD3: Consideration of emergent issues with the same collaborative described in RD1 (added in ver 1.5) (21 HDs)
- RD2: Sharing of data relates to access to care (20 HDs)
- RD2: Sharing of data with the same collaborative described in RD1 (19 HDs)
- RD2: Evidence of sharing data (16 HDs)
- RD3: Addresses emerging issue that will impact services (added in ver 1.5) (16 HDs)

Measure 7.1.3: Identification of gaps in access to health care services and barriers to the receipt of health care services identified

Of the 83 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD2a: Assessment of capacity and distribution of health care providers (53 HDs)
- RD2b: Availability of healthcare services (49 HDs)
- RD2c: Identification of causes of gaps in services and barriers to receipt of care (48 HDs)
- RD2d: Results of data gathered periodically concerning access (43 HDs)
- RD2: Analysis/conclusions to develop strategies (26 HDs)
- RD1: Process specific to gaps in access (i.e., documentation was of CHA process rather than of process related to access gaps) (added in ver 1.5) (12 HDs)
- RD1: Identification of parties involved (added in ver 1.5) (12 HDs)
- RD2: Provision of 2 examples (10 HDs)

Measure 10.1.1 -Applicable evidence-based and/or promising practices identified and used when implementing new or revised processes, programs, and/or interventions

Of the 27 HDs assessed as SD/ND, the most common challenges with documentation were:

- Out of PHAB's scope of authority (16 HDs)
- Evidence base not applied to implementing new or revised processes, programs, or interventions (16 HDs)
- Out of Timeframe/No date (6 HDs)
- Source of evidence base not cited (6)

Measure 11.1.4: Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes (ver 1.5 only)

Of the 12 HDs assessed as SD/ND, the most common challenges with documentation were:

- RD1: Health inequities incorporated into the development interventions and materials (8 HDs)
- RD2: Processes, programs, or interventions provided in a culturally or linguistically competent manner (5 HDs)

Community Health Improvement Plans

PHAB reviewed the CHIPs submitted by 320 accredited HDs (including the health departments accredited as part of the centralized state integrated local public health department system in Florida) and extracted and then categorized the indicators they are using to track progress towards health improvement in their jurisdictions. Among those CHIPs, 85% had at least one indicator related to Nutrition, Physical Activity, and Obesity. Specifically, 50% had one or more indicators related to obesity rates. Other indicators focused on:

- Individual behavior:
 - Physical activity/inactivity levels (43%)
 - Healthy eating patterns (31%)
- Physical environment:
 - Access to healthy food (39%)
 - Access to exercise opportunities (30%)

The following are other chronic disease related indicators that appeared in at least 10% of the CHIPs:

- Tobacco use (38%)
- Diabetes (12%)
- Poor mental health days (12%)

Because social determinants of health play a central role in chronic disease, it is also worth noting that about half the CHIPs had at least one indicator related to social environment.

Population Health Outcomes Tracking

As health departments apply for reaccreditation, they are required to indicate the population health outcomes they are tracking in their community. The graph below represents all the chronic-disease related indicators that were selected by 50% or more of the 52 health departments that had reported their population health outcomes as of early February 2020.

