

Performance

**Exploring Public
Health Experience
with Standards and
Accreditation**

Is it time to
stop talking about
how every health
department is unique?

A report prepared
by Lee Thielen
for The Robert Wood
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Standards

ACCREDITATION
OF PUBLIC HEALTH AGENCIES

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EXECUTIVE SUMMARY

Public health protects our citizens, creating healthier and safer communities. The intentions are honorable; the goals are salutary; but the processes and benefits used are not always well understood. In recent years, public health leadership has recognized the need for instruments, tools, and systems that show and measure the capability of public health to meet the challenges of our times.

Many states have spent a decade or more developing systems that measure the quality and the capacity of public health agencies. These laboratories of excellence are leading the field in identifying, measuring, and improving public health results.

States have chosen different routes to show what public health is and what public health can do. Programs vary regarding mandatory versus voluntary efforts; self-reporting versus third party reviews; standards versus accreditation. They also all have similarities, such as the use of accepted standards, consideration of national tools, a desire to tell the public health story and assure the public, and a focus on improvement of services.

This report, prepared for The Robert Wood Johnson Foundation, reviews the positions that the major public health organizations have taken on accreditation and comparable programs. It also includes a review of a number of innovative programs that are shaping this issue. In addition, the report notes trends, findings, and themes that surfaced during interviews with the people who are shaping this movement.

The major themes and findings of the report can be summarized as follows:

- Local public health agency accreditation is far ahead of any efforts that might lead to accreditation at the state agency level.
- Leadership at the local level is the key to success. State leadership provides resources, support, and coordination.
- Funding from the state to local public health agencies for discretionary or block programs drives most efforts, especially mandatory accrediting and standard-setting programs.
- National accountability instruments and processes, especially the Ten Essential Services and the National Public Health Performance Standards Program, have influenced state efforts.

- Semantics matter. Terminology can influence acceptance of standards setting and review processes.
- Other state agencies may use the certification process of the state public health agency as a seal of approval for contracting with local agencies.
- In some states, public health institutes are being used as the objective, third party that credentials the public health agencies.
- The Robert Wood Johnson Foundation's Turning Point Grants have been a contributing force in several states that are now practicing some form of credentialing.
- Workforce qualifications have a place in some agency credentialing efforts and are considered important by some of the nation's public health leaders.
- There is limited agreement regarding a vision for a national accreditation program.

INTRODUCTION

Accountability in public health is not a new concept. Public health leaders at the local, state, and national levels have long recognized that public health needs consistency for citizens to know that public dollars are being well-used to keep people healthy and safe. Public health officials have to communicate with the decision-makers in the city halls, state Capitols, and in Washington. To say that all health departments are unique doesn't make a strong case for understanding what public health does or why it is needed. Quality services and predictable results are expected both within and outside public health doors. One of the ways that accountability has been demonstrated is through standard setting and recognition of agency capacity through accreditation or certification.

The Robert Wood Johnson Foundation convened a small meeting in the summer of 2004 to discuss whether a forum on exploring accreditation of public health agencies would promote a useful dialogue for the major public health organizations. This paper was commissioned to prepare participants for further discussion in late 2004.

Definitions of terms may be useful for the discussion.

Accreditation may be defined as “the periodic issuance of credentials or endorsements to organizations that meet a specified set of performance standards.” (Novick and Mays, Public Health Administration, p. 765).

Credentialing is also commonly used to denote the establishment of requirements and evaluation of individual qualifications for entry into a particular status. It can be used as a broad term that encompasses issues of regulation, policy, education, and practice and may refer to credentialing of the workforce or the agency. **Certification** is a process by which an organization grants recognition to an individual or an agency that has met certain predetermined qualifications. Certification may imply a less formal process of receiving recognition than accreditation. For purposes of this discussion, the terms “credentialing”, “certifying” and “accrediting” may be used interchangeably to describe an agency meeting agreed upon standards.

Examples of public health accreditation at the state level are showing, once again, that states can be laboratories for change. This paper looks at many initiatives that states have taken to promote accountability in public health. Many of these efforts reflect a decade or more of local/state deliberations and building blocks of planning and public health improvement. Some use the term “accreditation”, some use the term “standards.” Often, the differences and similarities can best be seen in the processes and the products, not the semantics.

The efforts all focus on defining, measuring, and assessing public health agency capacity.

In addition, the major public health organizations were all asked their positions on public health agency accreditation. There certainly is no official consensus on the topic. However, a closer look at what the organizations are doing, their programs, and their history, shows that all of these organizations support accountability in public health, and all of them have been actively involved in the development and promotion of accountability tools. There is great reticence in taking a position that can impose perceived obligations on a divided membership of an organization, but the concept of accountability is well accepted by all the major organizations.

MAJOR FINDINGS AND THEMES

Discussions with public health leaders from major organizations and a look at the various state efforts illuminate some key themes and findings that may provide useful lessons about accreditation initiatives across the country.

Local public health agency accreditation is far ahead of any efforts that might lead to accreditation at the state agency level.

There is no real momentum for state health agency certification, while there are many examples of innovative programs at the local level. Some states are using the National Public Health Performance Standards Program instrument for state agencies to show state level participation while the local agencies are undergoing certification processes. Others, such as the state of Washington, are noting state responsibilities that match local responsibilities for each state standard.

Leaders representing the interests of local health agencies speak to the need for parallel development, but limited activity at the state public health agency level has occurred to date. State public health agencies do not have the same history as local agencies in the use of accountability instruments and in seeking commonalities in services. State agencies have focused more on developing common approaches to policy and advocacy than on self-improvement tools created through their joint efforts. State agencies are also perceived as politically sensitive with health officials needing to avoid getting ahead of their Governors in actions that could put pressure on policy and budgetary decisions and limit flexibility. In addition, state health officials often have limited tenure and, occasionally, less public health experience than the directors of major local public health agencies. These processes require long-term investments and commitments.

State health agencies are drivers for local public health accreditation, providing leadership, resources, and staffing to establish programs and systems of review.

Leadership at the local level is the key to success.

States that are the laboratories for the rest of the country in accreditation and standard-setting efforts achieved their current success and status due to champions at the local level. This enthusiasm for agency accountability is most likely to occur where there is a history of trust between the local health directors and staff and the leadership and staff at the state health agency. Without that trust, the risks appear too great for local agency buy-in. Success appears to require an inclusive process, especially one driven by local health directors. Collaborative leadership approaches by the state health agencies set the tone and create the environment in which this local leadership can flourish.

Funding from the state to local public health agencies for discretionary or block programs drives most efforts, especially mandatory accrediting and standard-setting programs.

Local health directors and state leadership recognize that discretionary funding is also fragile funding. Without a hook of maintaining certain standards and services, the state funding can easily evaporate. Some states have developed certification and standard setting as a defensive measure to protect state support. As two local health officials stated, *“Money helps drive this. If the state isn’t making an investment, who cares?”*

National accountability instruments and processes, especially the Ten Essential Public Health Services and the National Public Health Performance Standards Program, have influenced state efforts.

State and local agencies use tools that provide a framework that can be tailored to local terminology and practice. Agreement on standards and/or performance measures is a clear pre-cursor or a first step in any accreditation process. The work done to create the numerous instruments now available to public health agencies has been a good investment.

Semantics matter.

Some states achieve the same results with “standards” that others achieve with “accreditation.” The term “recognition” has also been used and is sometimes viewed as a more acceptable word than “certification” in the early stages of an accountability process or when there is concern about the implication of a guarantee. The term “accreditation” may be a red flag for some jurisdictions, and progress may be better served by using other terms. If compliance with standards is mandatory for contractual or grant requirements, and an objective review process exists for measuring against those standards, there may be little, if any, difference from certification efforts as practiced in other states. Which, for example, exhibits more clout – voluntary accreditation or mandatory standards review? There are many processes being used. Standards may include site visits; certification may be based on self-reporting. It is probably not helpful to place too much emphasis on the terms that programs are using because the nature of the processes illustrates more than the words used.

Other state agencies may use the certification process of the state public health agency as a seal of approval for contracting with local agencies. Human Services, Agriculture, and Environmental Protection Departments are using public health accreditation as a way to show the ability to perform services at the local level. This is a benefit of accreditation that may not be fully understood or appreciated. In some states, this benefit leads to de facto mandatory certification. In order to participate in contracts with other state agencies, the local health agency needs to

have the affirmation, often certification, from the state health agency. This is strong motivation for participation.

In some states, public health institutes are being used as the objective, third party that credentials the public health agencies.

North Carolina, Missouri and Michigan credential local health agencies through third party, independent non-profit organizations. The role of public health institutes as honest brokers in a potentially contentious process is important in several states. The growth of these institutes has been geometric as state health agencies and other organizations have seen the need for a non-governmental partner. Several of these institutes have surfaced after Turning Point initiatives identified a need for their services.

The Robert Wood Johnson Foundation's Turning Point Grants have been a contributing force in several states that are now practicing some form of credentialing or certification.

The funding available through Turning Point and the process of bringing a broad community coalition together to discuss public health improvements have contributed to the discussion and the actions that resulted in standard setting and credentialing programs. The Turning Point Collaborative on Performance Management is recognized as providing a service in institutionalizing a model for performance management.

Workforce qualifications have a place in some agency certification efforts and are considered important by some of the nation's public health leaders.

Agency certification often includes a requirement for workforce qualifications. In some cases this is at the local health official level; in others it includes other key staff positions. As one state health official noted, *“Our public health is only as good as the people we have in public health. If you have trained, credentialed people, you begin to have some assurance that you will have good public health.”*

Missouri, for example, uses staff competencies and minimum training standards for accreditation. Illinois and New Jersey set requirements for local health officials. Although the current momentum is for progress in agency accreditation, a qualified workforce is part of that dynamic.

There is no clear vision for a program that would provide national accreditation.

If asked, parties would agree that an objective third party would be the way to accredit public health agencies. The public health leadership would also agree that CDC cannot be the vehicle for that accreditation, but CDC could provide incentives for both a national program and for state programs. There is also

concurrence that any national program would have to be voluntary. Additionally, there is a strong sentiment that some movement is afoot and that agencies and organizations should prepare for that possibility.

Some states are designing programs that “will position them for any national program which might occur.” There is also some sense that a national agreement on basic standards that can be used and enhanced at the state level for state implementation would be beneficial.

The different approaches to accreditation by the major member public health organizations reflect the different histories and orientations of those organizations.

HISTORY OF ACCREDITATION ACTIVITIES IN PUBLIC HEALTH

Current efforts in public health accountability and capacity evaluation have been built on a foundation laid by previous efforts. The work of the National Association of County and City Health Officials, the Centers for Disease Control and Prevention, the Association of State and Territorial Health Officials, the National Association of Local Boards of Health, the Public Health Foundation, and the American Public Health Association have led to a number of useful tools and processes. These tools provide building blocks for the progress that is now being made. Some of the most influential tools are described below.

- **Assessment Protocol for Excellence in Public Health (APEXPH) and the Assessment and Planning Excellence through Community Partners for Health (APEXCPH)**

These instruments were developed as self-assessment workbooks that assessed the internal capacity of public health agencies and community capacity indicators. The later versions of APEXCPH used the Ten Essential Public Health Services to align the various indicators.

APEX has been a popular tool. From its unveiling in 1991, over 40 percent of the local public health agencies used part or the entire instrument (source: 1995 NACCHO Survey). Part One provided a guide for local health agencies to assess and improve their organizational capacity. Assessment of organizational capacity is a component of current credentialing initiatives.

- **Mobilizing for Action through Planning and Partnerships (MAPP)**

Mobilizing for Action through Planning and Partnerships is a community-based strategic planning tool. It was developed through the joint efforts of NACCHO and CDC and released in 2001 after five years of development.

- **National Public Health Performance Standards Program (NPHPSP)**

The national performance standards project enlisted the major public health organizations to develop three instruments that address and measure performance against standards for state and local public health agencies and for governance. The project took four years to develop and was officially launched in 2002. The standards are based on the Ten Essential Public Health Services and reflect optimum or stretch standards. The use of the standards is expected to increase accountability at the state and local level, improve the quality of services, and increase the use of science in public health practice. MAPP looks at the total public health system, not just the public health agency, creating concerns about whether the agency will be held responsible for matters outside their control, if used for certification.

The local instrument is closely related to the MAPP tool and was developed through the efforts of NACCHO and CDC. ASTHO has been the driving force for the state component, and the National Association of Local Boards of Health (NALBOH) has supported the development of the governance instrument.

- **Operational Definition of a Functional Local Public Health Agency**

The definition of a local public health agency will provide a foundation for standard-setting that can be used by the various efforts across the country. The project is not complete, but a public draft can now be viewed on the NACCHO website. The project assumes that there are roles that the local public health agency cannot delegate or assume that others will perform. It uses the Ten Essential Services to frame the activities that show how a local public health agency fulfills its governmental role.

WHAT THE FIELD SAYS ABOUT ACCREDITATION OF PUBLIC HEALTH AGENCIES

The future of the measurement of public health through standards and accreditation efforts will be determined by leadership, especially at the national level. Leaders from the major public health agencies were interviewed on the topic to identify where their agencies stand on accreditation. The responses show some congruence, some support, some differences, and many unanswered questions.

- **Institute of Medicine (IOM)**

“Despite the controversies concerning accreditation, the committee believes that greater accountability is needed on the part of state and local public health agencies with regard to the performance of the core public health functions of assessment, assurance, and policy development and the essential public health services...Accreditation is a useful tool for improving the quality for services provided to the public by setting standards and evaluating performance against those standards.” (The Future of the Public’s Health in the 21st Century, Institute of Medicine, 2003, p. 157)

The Committee on Assuring the Health of the Public in the 21st Century reflected the struggles that the public health community has with the concept of public health agency accreditation. The recommendation that was crafted did not recommend accreditation, rather that a “national commission consider if an accreditation system would be useful for improving and building state and local public health agency capacities.” (p. 9). Major organizations state that their members are “all over the map” on the issue. In spite of rather forceful narrative in the IOM report about the possible advantages of accreditation, the recommendation shows the compromises that were made by conflicted committee members.

- **National Association of County and City Health Officials (NACCHO)**

“There is a belief that accreditation has a momentum, a belief that something is afoot.”

NACCHO Official

NACCHO has provided its members with many tools and instruments over the years that support accountability and show what local public health does and why it should be valued. These tools are, in the words of a NACCHO official *“bricks in the wall, not a direct line to accreditation.”*

In July 2004, the NACCHO Board passed Resolution 04-06 which supports the establishment of a voluntary accreditation program with the potential of moving to a national program of accreditation as long as eleven provisions are met. These provisions reflect concerns about the role that NACCHO will play in designing a national system, the use of the operational definition of a functional local public health agency, avoiding unintended consequences and negative shifts in resources, an evolutionary process that starts with minimum or moderate standards, barriers caused by the costs of accreditation, and other procedural concerns. This resolution updates a previous position taken by the NACCHO board in 2001. NACCHO is one of two major public health organizations that have taken a clear policy position. The Executive Director of NACCHO cites the IOM study, CDC interest, and state efforts as components of the movement to show public health accountability. The focus on readiness has shown that it is difficult to show accomplishments or capabilities without measures.

- **Association of State and Territorial Health Officials (ASTHO)**
“This is a serious topic for ASTHO for the next year. We are supportive of the process, but wary of it as well.”
ASTHO Officer

ASTHO has a history of involvement in numerous initiatives that promote public health accountability and assessment. That history includes support of Model Standards for Communities in the 1970s to the current involvement in Bioterrorism Accountability Indicators and National Performance Standards. The organization has also had a history of being concerned about measures that limit a state’s ability to respond to its own needs and political environment.

There is no official position on public health agency accreditation, and leadership has expressed skepticism, primarily about concerns related to unintended consequences, administrative costs, and staff burdens. Many states are now learning laboratories regarding the advantages and difficulties with standards and accreditation. State health officials are instigating and supporting innovative approaches at the state level. ASTHO plays a key role of showcasing those efforts through various meetings and events.

An ASTHO Official states, *“If and when anything is done, it must be for the public good. We must ask By whom? For what purpose? To what end?”*

- **American Public Health Association (APHA)**

“Any model has to be flexible enough to work across the states.”

APHA Official

The American Public Health Association has not taken a position specifically on accreditation of public health agencies. However, APHA has been supportive of numerous efforts related to accountability in public health.

The Association helps market the National Public Health Performance Standards and supports the MAPP efforts of NACCHO. APHA has stepped back from credentialing the workforce, although they support the efforts of the Association of Schools of Public Health to move forward with plans to credential masters level public health professionals. The Association is more comfortable with supporting agency accreditation than professional credentialing at this time.

The role of APHA may be to support the state affiliates in their relationships with the accreditation activities at the state level. An APHA official has stated that this effort is part of the discussion about improving public health infrastructure, but the APHA members are not of one mind on what needs to be done.

- **National Association of Local Boards of Health (NALBOH)**

“As the policy-makers and overseers of local public health, boards of health support national efforts to set performance standards for quality improvement, accountability, and advocacy purposes.”

NALBOH Board Member

The NALBOH Board of Directors passed a resolution on October 23, 2004 related to accreditation of local public health agencies. They were unanimous in their support, in principle, of the concepts of accreditation and the current efforts towards accreditation. Their resolution includes a provision that such accreditation must include the governance of each agency as a core, fundamental factor in accreditation with specific aspects of governance included in the planning for such efforts.

A NALBOH official notes that health care organizations seek accreditation because it offers an objective evaluation of the organization’s performance. The same reasoning applies to public health agencies. Any costs associated with accreditation should be funded and not be another unfunded mandate.

- **Centers for Disease Control and Prevention (CDC)**

“Those engaged in the public health field are the authorities on standards. “

CDC Official

The Centers for Disease Control and Prevention have not taken an official position on public health agency accreditation, but the voices of CDC frequently speak of an idea whose time has come. Accreditation is a topic that is being discussed at the highest levels in CDC and was a major issue raised and studied during the Futures Initiative. A prominent CDC official sees CDC as a convener, facilitator, and catalyst for national accreditation. CDC is considering incentives to support state efforts and provide assistance and internal systems approaches at CDC that will support those efforts. He notes that the approach will be “*carrots, not sticks.*”

A new effort titled the Improving States Services Program will pilot placing senior CDC officials in the offices of state health officials to coordinate CDC relations and programs at the state level. This effort will be expanded, if successful. The program is seen as a way to move beyond the program silo relationships between states and CDC.

The CDC Futures Initiative Health Systems Work Group released a report in January 2004 which recommended implementation of national performance standards and development of an accreditation system. Accreditation was seen as a way to assure policy-makers and the public at large of the capacity of public health agencies and provide incentives for continuous improvement for public health agencies. (*Health Systems Work Group Report* as described by internal CDC documents)

From CDC’s perspective, any national accreditation system would have to be voluntary, run by a non-governmental third party, have standards set by the field, and recognize any state process for accreditation or standards reviews. National leadership will be necessary for progress to be made.

- **Possible Roles for CDC in Accreditation of Public Health Agencies**

There is general agreement about the appropriate roles that CDC can, and should, play to support accreditation efforts. These include:

- Funding of the infrastructure work needed for the accreditation process and continued support for accountability instrument development.

- Identifying minimum criteria for any state's accreditation program.
- Sponsoring forums for exchange of information and evaluation of tools and processes.
- Evaluation of accreditation programs and their impact on the health of the community.
- Providing support for training, technical assistance, consultants and peer assistance for state and local programs.

There is some support, and some fear, that CDC will use its grant making and cooperative agreements to support and reward accredited programs, especially for competitive grants. Rewarding accredited programs will be difficult due to the spotty availability of state accreditation efforts and the great variety in those that currently exist.

CURRENT STATE AND LOCAL EFFORTS

States have been involved in reviewing local public health agencies for many years. Some of the states that were studied have over ten years of experience in reviews of agencies against standards and in administering official accreditation programs. Some of these programs are voluntary. Others are mandatory. Some use a process of accreditation while others use a review against standards, avoiding the term “accreditation.” In addition, some programs are based on self-assessment, while others have third party survey teams that review the agencies. These programs are evolving and all strive to keep improving and adjusting with experience. Most of the programs are linked, in some way, to receiving state funding. All of these programs require a significant investment in staff time and resources at the state and local level, often during times of decreasing funding. Interviewees for this paper related whether the effort was worthwhile. Some of the representative comments include:

“People have to be able to expect certain things in every public health jurisdiction.”

“How long can we afford to support 50 unique systems?”

“States have a huge fear of being compared.”

“This all started with local health departments coming together.”

“We need something to assure the quality of public health services.”

“Money helps drive this.”

“It has made a difference in the quality of services.”

“Accreditation is a political plus, and the process just keeps getting better.”

“Accreditation helps me to tighten up. There has been a reduction in waste and duplication of services.”

“This is a way to speak across the state about what we do and how we do it.”

“We should have a drop dead date for this, say 15 years for a national mandatory approach.”

MICHIGAN: FROM CONTRACT COMPLIANCE TO CAPACITY ASSESSMENT

“Local health departments came together and said, ‘We want to do this.’”

Michigan Department of Community Health Official

The Michigan Local Public Health Accreditation Program is perhaps the most mature and institutionalized accreditation initiative in the states. It started in the early 1980’s as a next step from efforts to create a more efficient and effective way to contract with local health departments. The impetus for the effort came largely from local health directors who desired a master contract and consistent requirements from the state for program activities and measures. The local directors were concerned about negotiating with as many as 30 programs from the state, each with different requirements for evaluation, budget, formulas, reporting standards, and contracts.

The program is operated by the Michigan Public Health Institute, which is an independent non-profit organization. The Institute receives a contract for about \$218,000 annually from the Michigan Department of Community Health. This money comes from state funds that include special purpose monies raised from tobacco taxes and general fund dollars. The Michigan State Departments of Community Health, Agriculture, and Environmental Quality use the process as a mechanism for program review and contract compliance for services. Local health agencies receive state funding of about \$41,000,000 for numerous programs from the state agencies.

Every local health agency is required to participate in the program. A self-assessment is mailed six months prior to a visit by a team of up to nine state and contract employees. The self-assessments are not required to be submitted. They do help the agency prepare for the on-site review. The results of the on-site reviews are given to the Accreditation Commission, a committee of the Institute. The Accreditation Commission recommends accreditation, which is then offered through the executive directors of the three state agencies.

The process includes more than contract compliance; it looks at administrative capacity as well. Health assessment, policy development, quality improvement, health promotion, health protection, administration, and creating and maintaining a competent workforce are all reviewed. That aspect of the accreditation process is closer to efforts in other states and looks at such benchmarks as the Ten Essential Services, performance management measures, and the work of NACCHO in defining a functional local health agency as part of the continual review and improvement process for the accreditation program. The Michigan public health code (state statutes) provides the platform for the process. The

current focus is less on the contract with the state agencies and more on the legal obligations that the local agencies must meet.

Michigan is completing its second round of accreditation reviews. Round three will begin in October 2006. In the first round 10 of the 45 local agencies did not receive accreditation. A committee of local and state public health officials has been formed to clarify the consequences of failure to meet accreditation standards. To date, no agencies have been denied funding as a result of their review. One agency took four years to meet the standards. These problems are not anticipated for the second round, and eventually all agencies were certified in the first round. The program did take a “pause” during 2003 in which site visits were not performed. This was due to funding cuts in public health and a desire to look at the process through workgroups of local and state staff. Site visits were reinstated in February of 2004.

Reasons cited for failure to receive initial accreditation in the first cycle included:

- Some agencies were understaffed due to difficulties in filling vacant positions.
- Some agencies were resistant to the process due to their limited funding.
- Resistance to the staff work required for the process and as a reaction to change.
- Lack of documentation that verified what the agencies were doing.
- Uncertainty that accreditation would be a permanent program in the state.

Michigan uses the Accreditation Quality Improvement Process (AQIP) for a continuous quality improvement mechanism to review the program on a regular basis. This workgroup has surveyed all participants in all the levels of the program to provide feedback and improvement. The recommendations of the workgroup go to the Accreditation Commission which forwards them to the three state agencies for a final decision. The program has made changes to respond to the findings of the workgroup.

Agencies have used the process to highlight their services, celebrate their accreditation, and seek additional funding. One major urban department was able to receive considerable funding increases from the city to prepare for the effort. They received a total of \$5,000,000 of new funding to prepare for and meet the

accreditation process. Local public health directors who were interviewed were proud of what Michigan has accomplished and spoke comfortably about the political advantages of accreditation and how the process has improved public health in the state.

Lessons learned from Michigan: Tying accreditation to a strong public health code that defines local agency responsibilities, a state/local relationship that includes considerable funding from the state agency, and years of preparation driven by local leaders before accreditation was initiated all contribute to success in local health accreditation.

WASHINGTON: A LONG HISTORY OF ACCOUNTABILITY

“Common standards provide a clear and accountable measure of performance for public health agencies – a level of protection citizens can count on.”

Standards for Public Health in Washington State

The State of Washington has a tradition of accountability and measuring capacity in public health. Although the actual work of developing public health standards for the state and local public health agencies began in 1998, its roots go back much further. In 1992, all of the local health agencies participated in an APEX review. The state has used the Public Health Improvement Plan (PHIP), a biennial report, to set the mutual direction for local and state public health services. The legislatively mandated planning process called PHIP, fostered seven different work plan elements and related committees. One of the committees was called the PHIP Standards Committee which developed standards that the state and the local partners adopted.

The standards cover five key aspects of public health. These are:

- Understanding health issues
- Protecting people from disease
- Assuring a safe and healthy environment for people
- Promoting healthy living
- Helping people get the services they need.

In addition, the committee recognized a need to review basic administrative capacity.

Each area includes both local and state standards and measures. The standards are designed to be “stretch” standards, so that the bar is set for continuous improvement. A consulting team is under contract from the state health agency to review all health departments on a regular basis.

The committee chose not to use the Ten Essential Services as a framework for the standard. The Ten Essential Services were used to verify that important services had not been omitted. The five key aspects listed above do reflect the influence of the core functions of public health.

The state public health agency pays \$75,000 a year for a consulting team that does the site reviews and issues the reports. They also spend about \$6500 for travel and operating costs and contribute the time of a staff person, estimated at half of a full time equivalent position. Time spent by the local health departments has not been collected.

Evaluation includes an inter-rater reliability test for the process to obtain comparable results. They also use feedback discussions with the participants in regular meetings. The consultants also outline the pros and cons of the field experiences and submit recommendations to the Standards Committee which oversees the process and makes any necessary changes. They are expecting that the next evaluation cycle will show changes in performance on measures for the first time.

The process has run into some resistance, especially from the environmental health directors. Measures have been revisited and changed for greater acceptance by that group. The standards are not meant to replace program measures or cover all the work that public health performs. This also leads to some criticism.

Washington has very carefully avoided the concept of a test that has to be passed and instead focused on what should be. A state official noted, “The only way that these standards became embraced and important to people was to understand that they would not be used in a punitive way.” The focus stays on an intergovernmental partnership with mutual accountability.

State public health officials note that the political value of the process is tremendous, creating a view of public health as a system, mutually accountable and dependent, thinking ahead and protecting the public. The state contracts with the local public health agencies for \$17,000,000 of services funded with state moneys. The total funding to the local health agencies is \$65,000,000 from all sources.

Lessons from Washington: The success in Washington appears to be driven by a grassroots and locally supported process. The state law and state funding create an environment that supports accountability. Although the state does not use “accreditation,” it appears to accomplish many of the same goals through a different approach. The trust of local health departments has been nurtured with over a decade of planning and statewide reviews. Participation is an impressive 100 percent.

MISSOURI: A VOLUNTARY MODEL

“One of my priorities has been to bring more accountability to all departments, and the Health Department has established itself as a leader by demonstrating this level of service and voluntarily opening the department to independent review.”

Kansas City Manager

The state of Missouri has worked for many years to develop a voluntary program that accredits local health agencies. The Missouri Department of Health and Senior Services has supported the development of standards that are based on The Ten Essential Services of Public Health. As of September 2004, the program is fully operational. Five local health departments have completed the self-assessment, had a site visit, and are now accredited by the Accreditation Council. These include Kansas City, St. Louis, Butler County, Springfield/Greene County, and Mississippi County. Another agency is in the pipeline, with more expected to volunteer.

The Missouri Program started with work done ten years ago to define the roles and responsibilities of the state and local public health agencies. Over the years, task forces recommended a number of improvements, including creating a Center for Public Health Services and designing a program of accreditation.

The Missouri Institute for Community Health, a not-for-profit organization, manages the Accreditation Council for the Voluntary Accreditation Program for Local Public Health Agencies. The nine-person Council is appointed by the Board of the Institute to two-year terms. State health, local health, and academic organizations are all represented. The creation of the Institute was a direct result of the Turning Point Initiative in Missouri.

The agencies that volunteer pay a fee of \$2000 to \$4450 for the privilege of being reviewed. This fee covers the cost of the site visit only. The state health agency, the Turning Point Grant, and the Heartland Center for Public Health Capacity Development have all provided support to develop and operate the program. The current budget is from the Heartland Center for \$70,600 to cover a nine month period. The funding covers a small part-time staff. The local agency also has to expect that it will take three to five months to complete the self-assessment. A considerable commitment is required when volunteering to seek accreditation.

The on-site review team includes nursing, administrative, environmental, and quality assurance personnel.

There are three levels of accreditation: primary, advanced, and comprehensive. The size of the agency may influence the level that it is possible to achieve. Health departments accredited as advanced or comprehensive include components that are not included in the primary accreditation. The accreditation period is for three years.

The Accreditation Task Force identified five components for the accreditation process:

- Minimum standards based on the key activities from Missouri's Model of Core Functions
- Minimum standards and competencies for staff
- Community focus with identified community support
- Continuous quality improvement/quality assurance program
- Administrative services

Missouri chose to focus on evaluation of infrastructure, rather than programs. This is driven by a systems approach, reflecting the lessons from their Turning Point experiences. Comprehensive accreditation includes reviewing 68 performance indicators, with a score of 90 percent needed to achieve a passing score. Seven standards relate to facilities and administrative capacity. The agency is also reviewed for core staffing and training standards, noting educational preparation, technical skills and competencies.

The evaluation plan involves use of evaluation instruments designed to include baseline evaluation of the agency's status prior to going through self-assessment, evaluation of the process by the agency and the reviewers, and impact evaluation for the agency after receiving accreditation to show the effects of accreditation on the agency. Evaluation is being performed through a contractual arrangement.

Dr. Rex Archer, Director of Health for the Kansas City Health Department, volunteered his agency to be the first to seek accreditation in Missouri. Local officials state that other public services, such as education and hospitals, have an independent body that reviews them. Public health is just as important, and we can learn from the work that other fields have done. The City Council of Kansas City understands the value of accreditation as many of the members of the Council are current or past members of hospital boards and schools boards. There is a sense that the public deserves to know that public health will protect them.

The Kansas City Health Department found that the process was very affirming. Areas that the staff felt needed improvement were also those noted by the review team. Areas of strength were recognized as well. The self-assessment showed that the staff are harder judges than the review team.

The state health agency is using the National Public Health Performance Standards as a way to assess its strengths. This is supported by state funding and funding from the Heartland Center. A report is due this fall.

Lessons from Missouri: Missouri has a very comprehensive program for accreditation. It is voluntary and uses multiple levels of accreditation. Missouri is the laboratory to test whether a rigorous, volunteer program for local health agencies can be successful. Unlike other states, Missouri accreditation requires the local health agency to pay a fee to help fund the review process. Missouri may be an interesting model for those wishing to design a national system. It is comprehensive, voluntary, and fee-based.

NORTH CAROLINA: STARTING WITH A PILOT PROGRAM

“I was afraid they (local health officials) would say it wasn’t worth it, but it is just the opposite.”

Senior state health official, North Carolina Department of Health and Human Services

North Carolina has piloted local public health agency accreditation with six agencies. Four more agencies are part of the second round of pilot accreditation. The state appears to be headed for mandatory accreditation with considerable support from the local public health directors. The North Carolina Association of Local Health Directors Task Force on Standards and Efficiencies Accreditation Committee has recommended a mandatory approach with a single set of uniform standards.

The state legislature has given support to these efforts with an appropriation and legislation that defines the composition of a Pilot Accreditation Advisory Board. The Board is appointed by the Secretary of Health and Human Services. The legislation names the North Carolina Institute for Public Health as the home for the Board. The state legislature appropriated \$50,000 to support the advisory board and \$50,000 to be shared with the first six departments that volunteered for accreditation.

The report from the Accreditation Committee cited a rationale for accreditation. The committee noted that accreditation:

- Demonstrates core capacity to respond to public health challenges in their communities;
- Assures all citizens of North Carolina, regardless of county of residence, access to a standard of quality in core functions and essential services of public health;
- Improves efficiency and effectiveness of public health services as well as health outcomes across the state;
- Increases accountability for newly emerging communicable diseases; and
- Recognizes that access to an agreed upon minimum standard of quality in delivery of core services is essential to public health services. (North Carolina Public Health, Committee on Accreditation)

The Accreditation Committee developed a model that is similar to that used by Missouri. It is based on the core functions and ten essential services of public health with a focus on infrastructure, not programs. Unlike Missouri, North Carolina has chosen to have only one level with one uniform set of standards that all local health departments are expected to meet. The period of accreditation is four years, with a desire to have the health department pursue accreditation following the completion of a community health assessment. There is a provision for probationary status for up to two years.

Lessons from North Carolina: North Carolina may be the model of moving from voluntary to comprehensive coverage for accreditation. Local agency ownership and involvement in the process shapes this program.

ILLINOIS: A CASE OF CONTINUOUS IMPROVEMENT

“Improving public health one community at a time is the slogan for Illinois.”

Senior state agency official, Illinois Department of Health

The Illinois Project for Local Assessment of Needs (IPLAN) is a mandatory community health assessment and planning process for local health agencies. Conducted every five years, IPLAN leads to certification which is awarded by the state health officer of the Illinois Department of Health.

Prior to 1994, local health agencies received “recognition” for meeting minimal standards. Since then, compliance with IPLAN has been required to be eligible for local health protection grants. These grants provide the 95 certified local health agencies with \$14,000,000 which is distributed through a formula that includes a base grant of \$50,000 with the balance distributed based on population and poverty levels. Certification is also a requirement for participating in many of the programs housed in the Department of Human Services, such as intake point programs for Kid Care, Illinois’ Child Health Program.

IPLAN is grounded on the core functions of public health and public health practice standards and uses APEX-PH. Since 1994, Illinois has required an assessment using APEX every five years. The essential elements of IPLAN include:

- An organizational capacity assessment
- A community health needs assessment
- A community health plan that targets a minimum of three priority health problems.

To be certified, an agency must have a qualified administrator and an approved IPLAN. The state agency provides extensive technical assistance and on-line data resources to help the local agencies complete their requirements.

The Illinois Department of Health uses the state portion of the National Performance Standards to show their own accountability. Results from that assessment are regularly sent to the Governor’s Office. A state agency official of the Illinois Department of Health states, *“We do better when we model the way at the state level. The best thing we have done is to conduct a state level assessment and include local staff in the review of our state system.”* New legislation requires a state plan as well as the current requirements for local planning.

The State Board of Health will be required to submit a prevention focused State Health Improvement Plan every four years to the Governor for presentation to the General Assembly. The Director of the Department of Public Health will appoint a planning team with broad representation.

In the future, local health agencies will have a choice of using either the governance or the local section of the National Performance Standards in their planning process. Strategic planning in Illinois was helped with the Turning Point Grant from The Robert Wood Johnson Foundation which was implemented through the Illinois Public Health Futures Institute.

Lessons from Illinois: Illinois links certification to both discretionary state funding and to demonstrating the capability to participate in programs for the State Department of Human Services. Ten years of development have helped create a willingness to use national tools for local improvement.

NEW JERSEY: ADOPTING A SYSTEMS APPROACH

“Regulations approved in 2003 will change the way we practice public health in New Jersey.”

Senior state agency official, New Jersey Dept. of Health and Senior Services

New Jersey may be a small state, but it is rich in local health agencies. The state has 114 local health departments, representing 566 local boards of health. New Jersey has adopted 16 performance standards with 53 indicators of performance upon which all local health agencies must report. The Public Health Practice Standards of Performance used the national performance standards as a major foundation, as well as the Ten Essential Services and the Core Functions. MAPP has been adopted as the community health improvement planning tool and will be used by all agencies. An enhanced APEX process is being used as a self-assessment of local public health capacity. Aggregated data by county helps develop a cross-jurisdictional picture and approach. The governance portion of the National Public Health Performance Standards is also being used. Each local health agency completes an on-line Local Health Evaluation Report to meet regulatory requirements.

The state agency has used the national standards to show that they are willing to “practice what they preach.”

Although they are not implementing an official accreditation system, state public health officials at the New Jersey Department of Health and Senior Services note that accreditation may be part of the next generation of accountability. Changes in discretionary funding to local agencies from the state have created some tensions between the state and local public health agencies, but compliance has not, as yet, been impacted.

New Jersey has used accountability measures for decades; however, previous strategies included reporting the number of activities, rather than a systems approach. New Jersey has also had more stringent requirements for workforce qualifications than any other state. Health Officers and other key leaders have been certified by the state for many years. These requirements were updated and strengthened in the past few years. The Public Health Council, which operates as a state board of health, has shown leadership and vision in moving forward with the new performance standards, according to state officials.

Lessons from New Jersey: New Jersey has built on several national tools, modifying them as needed. In spite of changes in how local health agencies receive funding, the state has been able to achieve compliance with more demanding state regulations.

OHIO: USING STANDARDS

“We would never have gotten this far if we used the word ‘accreditation’. We use standards. They are a way to speak across the state about what we do and how we do it.”

Senior state agency official, Ohio Department of Health

Ohio uses six categories of Local Health District Improvement Standards that are similar to the wording in the Ten Essential Services for Public Health. They have been tailored to describe in terms that “non-public health people” can understand. Ohio uses 25 standards with up to 180 optimal measures. Local health agencies can select a measure for what is currently being done and a measure for what will be done for continuous improvement related to each standard. They also have the choice of providing a measure developed at the local level. The process included extensive pilot testing.

The process is based on self-reporting. They have cross-walked the standards with the draft of the Operational Definition of a Functional Local Health Agency and have reviewed the standards against the Ten Essential Services. Ohio learned from the Washington State experience with standards for local health agencies. Participation is required to qualify for state funding which is distributed on a per capita basis and can be used as flexible funding. Current appropriations are at \$3.2 million.

The process is based on rules of the Public Health Council, which require Ohio State Senate and House Resolutions. They expect to receive House support this year and have already gained the Senate Resolution.

Ohio has surveyed the participants to determine the utility, ease, functionality, and value of the improvement standards tool. In 2005, they will compile a single aggregate performance report for Ohio.

There were concerns about the new standards as they were developed; however, the standards have been endorsed by the local health commissioners’ association. Those with concerns worried about a perceived difficulty in completing the tool, perceived fear of consolidation with larger jurisdictions, and fear of “involuntary” accreditation.

The Ohio process is unique in its expectation that state-developed standards will be used for two years, followed by use of the National Public Health Performance Standards. They feel that this will position them well for any

possible national efforts. In the future, they may use national standards every five years. When the local agencies use the national standards, the state agency will as well.

Lessons learned from Ohio: Terminology may be as important as process. Acceptance may be easier if local health agencies help develop standards. Also, this state shows the value of learning from the work of other states.

FLORIDA: A CENTRALIZED APPROACH USING QUALITY MANAGEMENT

“In centralized systems, state leadership is more important, if not crucial. Local leadership may be less vocal.”

Public health faculty member, Florida State University, College of Public Health.

Florida has used accountability measures and processes for 15 years. Their framework has been focused on quality improvement, organized around the Baldrige Criteria.

Because Florida is a centralized system, it offers a different model from the other states that were examined. The Florida process includes a self-assessment with an extensive site visit annually for the largest local health departments and every three years for the smaller agencies. It combines program reviews with health status indicators, using both process and outcome measures. This top-down approach leads to mutual negotiations regarding both local commitments and state obligations.

Lessons from Florida: Florida is a model for centralized public health systems, using performance management at the local level.

PUBLIC HEALTH READY: A NATIONAL VOLUNTARY MODEL

Project Public Health Ready was designed as a partnership with NACCHO, CDC, and the Center for Health Policy at the Columbia University School of Nursing. Local health agencies volunteered to participate in a process that focuses on showing the capacity and ability of a local health department to respond to threats, whether from bioterrorism, infectious disease outbreaks or other public health emergencies. The concept includes using competency-based training and validation through exercises and drills. Core competencies of bioterrorism preparedness and response from Columbia University are used.

The partners chose to use the word the word “recognition” rather than “certification” to describe the affirmation that is given by a board that reviews the local health agency assessment, training plan, and testing through such mechanisms as drills. Interestingly, the word “certification” was used in the earlier materials. The evolution to “recognition” reflects the unease that the field has continued to show regarding the appearance of embracing certification of local health departments. It may also reflect concerns from the NACCHO Workforce and Leadership Development Advisory Committee which operates as the Oversight Committee. Certification could imply a guarantee or warranty, and the committee members expressed concern about the legal implications of using the term.

The project is significant for a number of reasons.

1. The process is voluntary.
2. The process is aimed at showing capacity of the local health agency.
3. A partnership with academia and the local health agency shapes the project, strengthening the role for academic preparedness centers with local clients.
4. The process includes strong support from NACCHO.
5. Public Health Ready has been very popular with hundreds of communities now wishing to participate.

To date, thirteen communities participated in Round One of Public Health Ready. Eleven have received recognition from the Oversight Committee for meeting all the goals and criteria related to preparedness planning, workforce development and training, and evidence of capacity through exercises or drills. The project has

become very popular with local health departments. For Round Two, 170 applications were received and 31 were accepted. Those accepted include 88 local health agencies, as a number of regional applications were made. The project is funded with federal Bioterrorism funds, although the local communities do not receive additional funding to participate.

Lessons learned from Public Health Ready: The project is voluntary and provides an opportunity to receive technical assistance from academic preparedness centers, the other participants, NACCHO, and ASPH. Local public health leaders can use the process to show local policy makers that public health is striving to build capacity to respond to threats, and the process can build upon expectations that already exist due to state and federal funding and mandates. Participating in the project is a way to organize staff in a positive way, justify workforce training, and show a proactive approach to emergency response. The success may have lessons for a voluntary national model of accreditation.

CONCLUSIONS

There are two contradictory approaches to describing public health. One is the oft repeated cliché that *“if you have seen one health department, you have seen one health department.”* The other is the extensive work, and almost universal acceptance, that public health indeed involves core functions and services. This dynamic shows the tension in a field which has a long history of independence and uniqueness and also feels the need to define its work and justify the resources invested.

The future of accreditation of public health agencies lies in a delicate balance. State and local jurisdiction independence is a factor and an asset in public health. That independence must be balanced with the recognition that a field of public health exists and can be measured and improved by defining and measuring agencies against standards that are understood and accepted. The work is not easy, nor can it be quick. One local health official cited 20 years of work that lead to his state’s accreditation program.

The states have contributed numerous models and approaches from which we can learn as the movement for greater accountability continues. Leadership at the state, federal, and local levels will determine whether a national model will provide additional value to public health accountability.

CONTRIBUTORS

American Public Health Association

Georges Benjamin

Association of State and Territorial Health Officials

Jackie Bryan

Brent Ewig

George Hardy

Richard Raymond (President)

Arkansas Department of Health

Fay Boozman

Paul Halverson

Centers for Disease Control and Prevention

Liza Corso

Ed Thompson

Maureen Lichtveld

Dennis Lenaway

Colorado Department of Public Health and Environment

Jeff Stoll

Florida State University

Leslie Beitsch

Illinois

George Rudis

Patti Kimmel

Illinois Public Health Futures Institute

Laura Landrum

Michigan Public Health Institute

Elaine Bean

Greg Cline

Melody Parker

Tracy Litzinger

Jeffrey Taylor

Michigan Department of Community Health

Jim Butler

Konrad Edwards

Debra Tews

Michigan Local Health Agencies

Bruce Bragg

Jon Houserman

Mary Kushion

Kimberly Singh

Missouri

Kathleen Wojciehowski

Shirley Rutz

Janet Canavese

NACCHO

Carol Brown

Librada Estrada

Grace Gorenflo

Pat Libbey

Rex Archer (President-elect)

NALBOH

Shepard Cohen

Marie M. Fallon

New Jersey Department of Health and Senior Services

Jim Blumenstock

Rich Matzer

Joe Aeilio

North Carolina Department of Health and Human Services

Joy Reed

Chris Hoke

Ohio Department of Health

James Pearsol

Public Health Foundation

Ron Bialek

The Robert Wood Johnson Foundation

Carol Chang

University of Illinois at Chicago, School of Public Health

Bernard Turnock

Washington State Department of Health

Joan Brewster

BIBLIOGRAPHY

1. Christenson, Gregory and Suzanne Dandoy, ed., *Research and Measurement in Public Health Practice*, American Journal of Preventive Medicine, November/December 1995.
2. Institute of Medicine. The Future of the Public's Health in the 21st Century, 2002.
3. *Journal of Public Health Management and Practice*, July 1998.
4. *Journal of Public Health Management and Practice*, September 2000.
5. *Journal of Public Health Management and Practice*, June 2003.
6. National Association of County and City Health Officials website, www.naccho.org.
7. Novick, Lloyd E. and Glen P. Mays, ed. Public Health Administration, Principles for Population-based Management. Aspen Publishers Inc., Gaithersburg, Maryland, 2001.
8. Public Health Foundation website, www.phf.org.
9. Public Health Foundation. Turning Point. Survey on Performance Management Practices in States, February 2002
10. Public Health Foundation. Performance Management in Action: Tools and Resources.
11. Extensive internal materials, documents and website information were provided by:

Association of Public Health Laboratories
Centers for Disease Control and Prevention
Illinois Department of Health
Kansas City Health Department
Michigan Public Health Institute
Michigan Department of Community Health
Missouri Institute for Community Health
National Association of County and City Health Officials
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APPENDICES: EXAMPLES FROM SELECTED STATES

Michigan



SECTION E¹: HEALTH PROTECTION

E1. The local health department assures a system for monitoring, inspection, intervention, and enforcement activities that eliminates or reduces exposure and risk from environmental threats and communicable diseases.

E1.1 The local health department employs epidemiologic tools such as sampling, cluster analysis, biomapping, interview techniques, or computer software to perform epidemiological analyses, either on-site or through an agreement with the state or other qualified entity, in order to monitor the environmental and communicable disease risks to the public.

To fully meet this indicator:

The local health department maintains on file written, final reports that include evidence of use of epidemiologic tools such as: sampling, cluster analysis, biomapping, interview techniques, or epidemiological computer software.

E1.2 The local health department employs legal mechanisms to assure compliance with health protection standards.

To fully meet this indicator:

- a. The local health department maintains on file statutes, codes, and ordinances employed to support enforcement activities or can demonstrate that local law officials and courts participate in development of enforcement policies; **AND**
- b. Maintains on file documentation of inspection, intervention, and enforcement activities associated with required services.

¹ This section is derived from recommendations of the Established Committee II, August 1992, 11/4/2003

Missouri

**Essential Service #1:
Monitor Health Status to Identify Community Health Problems**

Performance Standard 1:
Develop and maintain systems for collecting vital records, community and demographic data that characterize the health of the population, conditions that affect health, and the health system

Type(s) of Accreditation: Primary Advanced Comprehensive

Performance Indicator 1.1: Local vital records are collected on births and deaths and forwarded to the state health agency in accordance with standards for timeliness and accuracy.

Performance Measures:

- A __ Quarterly and annual reports from the Bureau of Vital Records show that the agency's average time for sub-Mission of Birth Certificates to MDHSS is acceptable when compared to state averages.
- B __ Quarterly and annual reports from the Bureau of Vital Records show that the agency's average time for sub-Mission of Death Certificates to MDHSS is acceptable when compared to state averages.
- C __ Quarterly and annual reports from the Bureau of Vital Records show that the agency's average time for sub-Mission of Fetal Death Certificates to MDHSS is acceptable when compared to state averages.
- D __ Quarterly and annual reports from the Bureau of Vital Records show that the agency's average time for sub-Mission of Home Birth Certificates to MDHSS is acceptable when compared to state averages.
- E __ Agency contacts origin facilities or groups when average time to submit records exceeds state averages to provide education on the importance of correct submission.
- F __ Agency documents education provided to funeral directors, Hospitals, and/or other appropriate individuals or sectors

Score:

- 1 = Local vital records are not collected and submitted to DHSS in a timely and accurate manner
 - 2 = Agency can demonstrate compliance with 1 of the 6 measures
 - 3 = Agency can demonstrate compliance with 2 of the 6 measures
 - 4 = Agency can demonstrate compliance with 3 of the 6 measures
 - 5 = Agency can demonstrate compliance with 4 of the 6 measures
- * In city agencies, not responsible for vital records, deduct 5 points from total possible points before calculating for threshold percentage.

Examples of Supporting Documents:
Reports from the MDHSS Bureau of Vital Records
Documented contact with origin facilities
Examples of education provided to origin facilities/individuals/population sectors

Notes:

North Carolina

Public Health Task Force 2004 Accreditation Committee Policy Workgroup

Recommended Standards for Public Health Core Function: Policy

Essential Service: Inform, Educate, Empower

- 11 Report results of analysis to appropriate audiences, including state/local health care providers.
 - 11.1 The results of community health assessment are shared with coalitions, community groups, and the general population through use of various media.
Documentation: Assessment is made available through websites, libraries, board meetings and coalitions such as local Healthy Carolinians.
 - 11.2 Reports summarizing community needs and available resources are published and disseminated.
Documentation: State of the County Health (SOTCH) report
 - 11.3 Information dissemination is culturally and linguistically appropriate and accessible to special populations (based on Office of Civil Rights (OCR)).
Documentation: evidence of translated materials, bilingual translators available at meetings, deaf/hard of hearing options, media policies reflect compliance with OCR.
- 12 Educate public regarding the availability of health-related data and respond to information requests.
 - 12.1 Information is provided to the public on local availability and location of health related data/analysis.
Documentation: brochures, website, press releases, weblinks
 - 12.2 A mechanism exists to reference and access available data and health information maintained by the Local Public Health Agency (LPHA).
Documentation: master list, table of contents, electronic database
 - 12.3 LPHA has policies and procedures in place to guide responses to requests for information from the general public, media, elected officials.
Documentation: Evidence of policies and procedures.
- 13 Evaluate and take steps to improve the availability, quality and utilization of health data.
 - 13.1 An annual evaluation is conducted of the agency's data system and its use of and access to data.
Documentation: Quality Improvement (QI) plan that includes annual review of health data availability; memos, minutes from meetings.

Washington State

Protecting People from Disease

Standards for Communicable Diseases and Other Health Risks

Standard 1

A surveillance and reporting system is maintained to identify emerging health threats.

Local measures:

1. Information is provided on how to contact the LHJ to report a public health concern 24 hours per day. Law enforcement has current local and state 24-hour emergency contact lists.
2. Health care providers and labs know which diseases require reporting, have timeframes, and have 24-hour local contact information. There is a process for identifying new providers in the community and engaging them in the reporting process.
3. The local BOH receives an annual report, one element of which summarizes communicable disease surveillance activity.
4. Written protocols are maintained for receiving and managing information on notifiable conditions. The protocols include role-specific steps to take when receiving information as well as guidance on providing information to the public.
5. Communicable disease key indicators and implications for investigation, intervention or education efforts are evaluated annually.
6. A communicable disease tracking system is used which documents the initial report, investigation, findings and subsequent reporting to state and federal agencies.
7. Staff members receive training on communicable disease reporting, as evidenced by local protocols.

State measures:

1. Information is provided to the public on how to contact the DOH to report a public health concern 24 hours per day. Law enforcement has current state 24-hour emergency contact lists.
2. Consultation and technical assistance are provided to LHJs on surveillance and reporting, as documented by case summaries or reports. Laboratories and health care providers, including new licensees, are provided with information on disease reporting requirements, timeframes, and a 24-hour DOH point of contact.
3. Written procedures are maintained and disseminated for how to obtain state or federal consultation and technical assistance for LHJs. Assistance includes surveillance, reporting, disease intervention management during outbreaks or public health emergencies and accuracy and clarity of public health messages.
4. Annual goals and objectives for communicable disease are a part of the DOH planning process. Key indicators and implications for investigation, intervention or education efforts are documented.
5. A statewide database for reportable conditions is maintained; surveillance data are summarized and disseminated to LHJs at least annually. Uniform data standards and case definitions are updated and published at least annually.
6. Staff members receive training on communicable disease reporting, as evidenced by protocols.