

Version 2022 Summary

Administration, Management and Governance of Health Departments Expert Panel Reviewers Summary Recommendations

April 2021



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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 transforming the quality and performance of governmental public health agencies in the U.S. and abroad.

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Background

As PHAB continues to work on Version 2022 of the accreditation Standards & Measures, a group of seasoned public health administrators very familiar with PHAB's accreditation criteria served as a virtual expert panel of reviewers. They provided feedback on proposed changes that were drafted based on potential alignment between PHAB's accreditation standards with the 2020 refreshed [Essential Public Health Services](#) (EPHS) framework; the [Council on Accreditation standards](#); the [ASTHO Dashboard](#); the [Uniform Chart of Accounts](#); and, a report developed by Georgia Southern University entitled "[The Administration and Management of COVID19 Contact Tracing Programs](#)." A more detailed report has been provided to PHAB, but this summary provides a synopsis of the major recommendations. Simple updates or proposed edits in wording are not included in this summary. Comments on the proposed changes that emerged from COVID-19 lessons learned are reflective of the responsibilities of administration and management, which are posed to augment earlier recommendations related to emergency preparedness and response. It should be noted that several recommendations were made to consolidate or delete requirements to balance the recommended additions.

Administration/Management

Organizational administrative competence is the capacity to lead internal and external stakeholders to consensus, with movement to action, and to serve as the public face of governmental public health in the health department's jurisdiction. It is also the capacity and skills to directly lead or actively engage in health policy development, discussion, and adoption with local, state, and national policymakers and to define a strategic direction for public health initiatives. It includes organizing, leading, and impacting the efforts of organizational human and other resources to make decisions and achieve organizational goals. *(Based on ASTHO Performance Dashboard and Metrics; COA Administration and Management Standards; FPHS; and Public Health 3.0.)*

Recommendations

- Change the title to “Maintain a strong organizational administrative infrastructure” to better align with the 2020 EPHS language.
- Add requirement that policies and procedures must be developed or revised to reflect specific intention regarding initiatives on health equity, discrimination, and racism as public health issues.
- New Measure Proposed: Add a new measure that addresses policies for infrastructure operations that address future uncertain challenges and/or disruption in normal operations.
- Measure 11.1.3: No proposed changes in measure of wording, except to remove the phrase “including applicable HIPAA requirements” from the measure stem and add it as an example in the guidance. There are multiple guidance documents and requirements for various programs that include confidentiality.
- New Measure Proposed: A new measure that requires an organizational process for ensuring that policies, programs, and interventions are not reinforcing cultural bias, barriers, and inequities. The health department must have a process for examining its organizational policies and procedures to ensure that they are not reinforcing cultural bias, racism, discrimination, systemic barriers, and inequities. The process should be based on an evidenced-based toolkit or framework.
- New Measure Proposed: A plan for staff recruitment, retention, training, and deployment/assignment during an unforeseen crisis. Human resource policies and procedures should be designed to specifically include future unforeseen circumstances such as a need to quickly address staff surge capacity, existing administrative capacity, diversity of populations served, specialized staff skill mix, desirable employee attributes, and challenges associated with adapting to a remote work environment.
- Measure 11.1.6: Rephrase this measure to state that the health department must have a systematic and strategic process for maintaining robust information technology services that are current, meet privacy and security standards, support analysis and distribution of health and program data, and provide updated means of communications.
- New Measure Proposed: The health department must provide its information/data governance process for developing, maintaining, and managing information systems as well as maintaining data integrity.
- New Measure Proposed: The health department must provide a written process for how to adapt their standard financial procedures to manage uncertain or unplanned public health events.
- Measure 11.2.2: Add a requirement under this measure that the health department must have a written process for assessing the timeliness and appropriateness of contract and invoice payments, in accordance with health department procedures.
- Measure 11.2.3 and Measure 11.2.4: The Uniform Chart of Accounts was recommended as one documentation mechanism for building financial reports and for educating about resources needed for public health functions.

Governance

The health department’s support and engagement of its governing entity in maintaining and strengthening the public health infrastructure for the jurisdiction served is vital to strong public health practice. Governing entities both directly and indirectly influence the direction of a health department and should play a key role in accreditation efforts.

Recommendations for the Governance component were initiated from two town hall sessions in 2018 and 2019 at the National Association of Local Boards of Health (NALBOH) annual conference. In 2020, those recommendations were intentionally reviewed for their application to other forms of governance. Some

clarity is needed in the introductory information that these requirements are specifically for health departments working with their governing entities, not requirements FOR the governing entity.

Recommendations:

- Measure 12.2.1: No change in the measure itself but require additional information about the process the health department routinely uses to interact with their governing entity. This sets the tone for the rest of the requirements in this domain.
- Standard 12.3: Add descriptive language in the standard overview to include how the health department and the governing entity communicate about strategies to manage uncertain and unplanned events (pandemics, outbreaks, natural disasters).
- Proposed change in the wording of the standard to: “Engage with the governing entity in developing strategies for carrying out the public health department’s obligations and responsibilities.” The rationale is that the health department is accountable for what it does to engage with its governing entity in the most effective manner. The type of engagement will vary based on the governance model.
- Proposed additional language under this same standard includes communication with the governing entity regarding science and evidence-based strategies to address unplanned public health events (pandemics, outbreaks, natural disasters, etc.). Examples may include how the health department provided information on the public health roles and responsibilities during a pandemic/epidemic, outbreak, natural disaster, or other unplanned event.
- Measure 12.3.2: Recommend the deletion of this measure: “Actions taken by the governing entity tracked and reviewed.” While it is important for the health department to be knowledgeable about the decisions made by the governing entity, PHAB has learned that it is difficult in practice to monitor and track those decisions formally.
- Measure 12.3.3: Communication with the governing entity concerning assessment and improvement of the health department’s performance is the current focus. However, adding a requirement about communication concerning the status of the CHA/CHIP, Strategic Plan, and Emergency Operations Plan would strengthen and broaden this measure requirement.

Expert Panel Virtual Reviewers

- Kathy Vincent, former Deputy State Health Officer, Alabama Department of Health and COVID-19 Region IV Coordinator for the CDC Foundation
- Kate Marone, Director of Healthy Lincoln County Medical Care Development, Inc. and former Accreditation Coordinator, Maine Department of Public Health
- Jeff Lake, former Deputy Director of the Virginia Department of Health and former PHAB Volunteer Services Coordinator
- Colleen Svoboda, Partnerships and Assessment Manager, UNMC College of Public Health and former Administrator, Office of Community Health & Performance Management, Nebraska DHHS, Division of Public Health
- David M. Souleles, Director, COVID-19 Response Team, Program in Public Health, Susan and Henry Samueli College of Health Sciences, University of California, Irvine and former local health official, Orange County, California.
- Margaret Rivello, former Director of the Chester County Health Department, PA.
- Mary Wellik, former Director of the Olmstead County Health Department, Rochester, MN
- Joe Kyle, former Deputy Director, South Carolina Department of Health

Version 2022 Lessons Learned

Administration, Management, and Governance of Health Departments – What Have We Learned from Accredited Health Departments?

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This document summarizes what PHAB has learned about how health departments (HDs) participating in accreditation are addressing administration, management, and governance activities. In particular, it focuses on the reasons that HDs struggled with measures that relate to administration, management, and governance.

Below is a summary of the distribution of assessments for related measures. These data are for 179 HDs assessed under Version 1.0 and 185 HDs assessed under Version 1.5.

Measure	% Fully Demonstrated	% Largely Demonstrated	% Slightly Demonstrated	% Not Demonstrated	N
11.1.1	68.10%	31.0%	0.8%	0.0%	364
11.1.2 (v1.5 only)	27.60%	39.5%	26.5%	6.5%	185
11.1.3 (was 11.1.2 in v1.0)	65.90%	31.3%	2.7%	0.0%	364
11.1.3 (v1.0)	53.60%	40.8%	5.6%	0.0%	179
11.1.4 (v1.5)	43.20%	50.3%	5.9%	0.5%	185
11.1.5 (v1.0)	61.50%	36.3%	2.2%	0.0%	179
11.1.4 (v1.0)	76.00%	21.2%	2.8%	0.0%	179
11.1.5 (v1.5)	45.90%	50.8%	3.2%	0.0%	185
11.1.6 (v1.0)	90.50%	8.4%	1.1%	0.0%	179
11.1.6 (v1.5)	56.80%	38.9%	4.3%	0.0%	185
11.1.7	56.90%	40.7%	2.2%	0.3%	364
11.2.1 (v1.0)	88.30%	9.5%	2.2%	0.0%	179
11.2.1 (v1.5)	82.70%	16.2%	1.1%	0.0%	185
11.2.2	73.10%	17.9%	2.5%	6.6%	364
11.2.3	87.40%	11.8%	0.8%	0.0%	364
11.2.4	80.20%	18.1%	1.6%	0.0%	364
12.1.1	90.90%	7.7%	1.4%	0.0%	364
12.1.2	94.00%	4.1%	1.9%	0.0%	364
12.2.1 (v1.0)	85.50%	7.8%	4.5%	2.2%	179
12.2.1 (v1.5)	56.80%	28.6%	11.9%	2.7%	185
12.2.2 (v1.0)	84.40%	3.4%	6.1%	6.1%	179
12.3.1	93.10%	5.5%	1.1%	0.3%	364
12.3.2	34.10%	16.8%	27.2%	22.0%	364
12.3.3	61.00%	23.1%	11.3%	4.7%	364

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. As shown in the table above, there are instances where the numbering changed between Versions 1.0 and 1.5. For example, a new Measure 11.1.2 was added in Version 1.5. As a result, the numbering for most of the rest of the measures in Standard 11.1 do not align.

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 and Measures. For reference, please see [PHAB Standards & Measures Version 1.5](#).

Measure 11.1.2: Ethical issues identified and ethical decisions made (version 1.5 only)

Of the 56 HDs assessed as SD/ND, documentation failed to demonstrate the following:

- RD1: An opportunity for input from affected stakeholders and consideration of their interests (34 HDs)
- RD1: Consideration of best evidence available (31 HDs)
- RD1: Opportunities to evaluate decisions as new evidence becomes available (30 HDs)
- RD1: Identification/resolution of ethical issues (28 HDs)
- RD1: Provision for accountability of the decision makers (26 HDs)
- RD2: Deliberation/resolution of the ethical issue (22 HDs)
- RD2: Example linked to process described in RD1 (10 HDs)

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

Of the 12 HDs reviewed under Version 1.5 of the Standards & Measures that were assessed as SD/ND, documentation failed to demonstrate:

- RD1: Health equity incorporated in the development of policies, processes, and programs (8 HDs)
- RD2: Culturally or linguistically appropriate processes, programs, or interventions (5 HDs)
- RD3: An assessment of cultural or linguistic competence (4 HDs)

Measure 11.2.2: Written agreements with entities from which the health department purchases, or to which the health department delegates, services, processes, programs, and/or interventions

Of the 33 HDs assessed as SD/ND, the most common challenges were:

- Agreements were not for services provided by others (19 HDs)
- Agreements were out of scope (9 HDs)
- Agreements were not for provision of services (8 HDs)
- Documentation was out of the date range/agreement not renewed (7 HDs)

Measure 12.2.1: Communication with the governing entity regarding the responsibilities of the public health department and of the responsibilities of the governing entity

Of the 37 HDs assessed as SD/ND, documentation failed to demonstrate:

- Communication of the health department's responsibilities (18 HDs)
- Public health governing entity's public health related roles and responsibilities (14 HDs)
- Provision of orientation (11 HDs)
- Authenticated communication to the governing entity (10 HDs)

Measure 12.3.2: Actions taken by the governing entity tracked and reviewed

At the time of this analysis, 170 HDs were assessed as SD/ND. **79 seemed to just generally miss the intent of the measure.** Other frequent issues were failure to document:

- Review of positions, issues, opinions (48 HDs)
- Review conducted consistently or at least annually (42 HDs)

- Identification of increased communications needs (31 HDs)
- Review of patterns of issues (27 HDs)
- Review of positions taken (20 HDs)
- Comprehensive review (i.e., reviewed just one issue) (20 HDs)
- Review of opinions of governing entity members (16 HDs)

Measure 12.3.3: Communication with the governing entity about health department performance assessment and improvement

At the time of this analysis, 56 HDs were assessed as SD/ND. Common challenges were:

- RD1: Discussion was not with governing entity (27 HDs)
- RD2: Missed the intent (20 HDs)
- RD2: Communication was not about the result of a performance improvement process/activity (20 HDs)
- RD1: Missed the intent (17 HDs)

Version 2022 Lessons Learned

Evidence Related to Administration, Management, and Governance of Public Health Departments



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Administration, Management, and Governance of Public Health Departments

Competent health departments require proficiency in organizing and leading action, building consensus with stakeholders, meeting organizational goals, and serving as the face of governmental public health in their jurisdictions.ⁱ Organizational management, administrative capacity, and governance of health departments include such important elements as data analytics, policy setting, strategic planning, finances, and communication. Work in each of these areas is connected to other important health department efforts, such as health equity, performance management, quality improvement (QI), ethics, and enforcement and compliance.ⁱⁱ

Administrative Evidence-Based Practice

Brownson et al. hypothesized that identifying and utilizing a specific set of administrative evidence-based practices (A-EBP) that can support health departments' achievement of core functions and implementation of evidence-based interventions may improve public health practice.ⁱⁱⁱ Their study identified a set of 11 high priority A-EBP that any type or size local health department could implement at a relatively low cost. These span five domains: workforce development, leadership, organizational culture, relationships and partnerships, and financial processes. The high-priority A-EBP identified included training in areas such as QI analytic decision-making and essential services; access to technical assistance; leadership quality and development; the values and expectations of leaders, including support of QI and accreditation; participatory decision-making; access to and free flow of information in the organization; an organizational culture of innovation and exploration; a learning orientation; collaboration with other health departments and community entities; a clear vision and mission guiding these partnerships; and the allocation and expenditure of resources with diverse funding and based on evidence, QI, and outcomes-based contracting, among others. This study offers health department leaders and administrators a guide to the management practices that support improvement in public health quality and practice.

Another study undertook to understand the elements that were predictive or demonstrative of A-EBP among local health departments.^{iv} Across the same five domains demonstrated by the previous study, this study found that among the A-EBP previously defined, A-EBP practices reported least by local health departments were those contributing to organizational climate/culture. The practices reported most included developing partnerships among health sector and other community entities and having a variety of funding streams. The authors noted that although organizational culture and climate are difficult to change, a more intentional focus on enhancing these through leadership training would strengthen the use of EBP in public health practice. A few additional observations were offered by the authors, such as the possible benefits of the use of knowledge brokers to address the gaps in EBP competencies across the public health workforce; a need for smaller local health departments to focus on the foundational capabilities; a recommendation that nursing education focus more on public health skills and science; and the benefits of academic-practice partnerships.

Budgeting, Funding, and Public Health Finance

The need for knowledge of public health financing and the availability of public health professionals trained in resource acquisition, allocation, and utilization has been abundantly described in the literature. The *Journal of Public Health Management & Practice* has published many articles on public health finance concepts, including a set of

financial management competencies to aid in building the related capabilities of the public health workforce.^v One such article describes Florida's comprehensive financial reporting system as an example of a public health system that allows the analysis and use of data regarding public health funding in the state and a detailed understanding of the costs of specific services. These can then be compared to unit cost benchmarks across the state. Other states too are showing progress in leadership in systems level financial analysis.^{vi} This interest in public health finance continues and making public health financial data available and accessible is an important opportunity to evaluate interventions that support population health improvement.

Many public health agencies face challenges with limited agency budgets. A study by Erwin, Shah, and Mays reviewed health department data to identify any potential factors that could be modified to protect health departments from the loss of financing and jobs during economic downturns.^{vii} They noted that the resilience of the health department was impacted by some factors that could be influenced by the health department and others that could not. They noted, "Overall, LHDs that successfully weathered the economic recession of 2008 were more likely to have relied on non-local sources of revenue, have a diversified service mix, and be located in communities with favorable socioeconomic environments." Successful resource and financial management that protect health departments from economic declines have value when considering the needed financial skills and capacity of the agency.

Braiding and layering of funding is a method that works to support public health efforts to meet specific objectives through combining funding from different sources. Ensign & Kain described that innovative health departments are using a "Public Health 3.0 funding model that uses braided and layered funds to focus interventions further upstream, including coordination and capacity building among community-level systems addressing social needs (midstream interventions) and enabling policy action to improve the social determinants of health (upstream interventions)."^{viii} This article demonstrates that this method requires committed strategic leadership, shared vision and prioritization, collaboration and empowered decision-making, well-developed cost allocation and budget reporting, and the dedicated, full-time staff to implement the process. This work, in states such as Colorado, Rhode Island, and Washington, has shown that the braiding and layering funding model serves to improve the impact on social determinants of health and achieve specific population health impacts.

One study compared the PHAB measures related to *Establish[ing] successful financial management systems* (Standard 11.2 in Version 1.5) to those used to establish accreditation in higher education.^{ix} It described the importance of public health departments demonstrating their capacity to manage grants and contracts, meet their funding agency requirements, establish and manage approved budgets, and generate finance reports to their governing bodies. This study made recommendations for activities that would add value to the assessment of financial readiness, such as taking a broader and more detailed financial picture of health departments, including detailing financial health and stability, as well as financial risk assessment and areas of deficit. Another important recommendation was that the allocation of resources in the agency's budget should show alignment with the health department's mission, strategic plan, and community health plans, which would help provide evidence of institutional integrity and sound financial management.

Strengthening Governance

One of the explicit goals of Version 2022 is to "promote accountability," which will require better understanding of the qualities that strengthen health department governance and that promote the engagement and support of the health department's governing body.

Governance authority and involvement provide important functions to support the work of the health department. The National Association of Local Boards of Health (NALBOH) created a taxonomy to define the public health governance functions as policy development, resource stewardship, legal authority, partner engagement, continuous improvement, and oversight.^x The continuous improvement function is critical to quality improvement and is a central attitude behind accreditation.^{xi} One of PHAB's foremost objectives is the continuous improvement of public health. One study looking at the continuous improvement function of governance noted that gaps in training local health board officers have persisted, with continued deficits in governance engagement in continuous improvement roles, and low engagement in the PHAB accreditation efforts of their local health departments.^{xii} This study found that local governing bodies' promotion and support of their local public health departments' accreditation efforts could lead to better population health outcomes. The authors also noted that governance oversight and engagement is strongly correlated with continuous improvement. Other strengths that engaged governing bodies demonstrated included meeting frequently, having board members who were health care or public health professionals, and how often the boards demonstrably advocated for public health.

In support of these findings, an analysis of National Association of County and City Health Officials (NACCHO) local health department surveys found that board members need more thorough training in their governance duties and public health issues,

and that a quarter of local health departments did not report governance support for funding public health activities nor discuss accreditation with them. There were areas of strength in governance that were identified, such as in policy development and oversight. Areas for improvement included governance participation in strategic planning and continuous improvement.^{xiii} As noted above, participation in continuous improvement is an important contributor to improved community health and health equity.

A qualitative study reviewed governance measures of accredited health departments and found that important drivers of health department leadership success and longevity were related to having a good relationship with and meeting the leadership expectations held by the governing body. This study also found that the reputation of the agency was an important factor, stating that "improving the agency's public health prominence and visibility and building up the agency were cited as crucial professional characteristics more often than having an impact on the status of the health of the public." It added that the findings of the study could be used to stimulate the creation of curricula to educate and train the public health workforce in these areas.^{xiv}

Caron et al. conducted a study to examine the contributory value of academic-governance partnerships, seeking to understand barriers to these types of collaborations and their utility in advancing public health workforce development. They noted that the main barriers that were identified by local boards of health had to do with a lack of time, staff, and funding, but that ultimately, academic partnerships with governing bodies broadened the access to expertise for public health improvement and had the potential to enhance the growth of the public health infrastructure. The authors stated that "academic-practice collaborations hold the potential to combine basic public health principles with leadership and governance experience offered by local boards of health" and "partnerships between academia and LBOHs can contribute to addressing local public health concerns by engaging multiple stakeholders, including academicians, students, and public health practitioners, as well as accessing varied resources, including funding, expertise, and infrastructure."^{xv} Seeking these types of partnerships may prove beneficial in overcoming some health governance deficits.

ⁱ Public Health Accreditation Board. (2021, April). *Version 2022 summary; Administration, management and governance of health departments expert panel reviewers summary recommendations*. https://phaboard.org/wp-content/uploads/2.0Administration-Management-and-Governance_Summary.pdf

ⁱⁱ Public Health Accreditation Board. (2021, September). *Focus on governance*. <https://phaboard.org/wp-content/uploads/Focus-on-Governance-One-Pager.pdf>

ⁱⁱⁱ Brownson RC, Allen P, Duggan K, Stamatakis KA, Erwin PC. Fostering more-effective public health by identifying administrative evidence-based practices: a review of the literature. *Am J Prev Med*. 2012;43(3):309-319.

^{iv} Brownson, R. C., Reis, R. S., Allen, P., Duggan, K, Fields R., Stamatakis, KA., & Erwin, P. C. (2014). Understanding administrative evidence-based practices: findings from a survey of local health department leaders. *American Journal of Preventive Medicine*, 46(1):49-57.

^v Honoré PA. Public health finance: contributions from the Journal of Public Health Management & Practice. *J Public Health Manag Pract*. 2019;25(1):17-18.

^{vi} Honoré PA. Public health finance: contributions from the Journal of Public Health Management & Practice. *J Public Health Manag Pract*. 2019;25(1):17-18.

^{vii} Erwin PC, Shah GH, Mays GP. Local health departments and the 2008 recession: characteristics of resiliency. *Am J Prev Med*. 2014;46(6):559-568.

^{viii} Ensign K, Kain JC. State of public health: braiding and layering funding doing more with what we have. *J Public Health Manag Pract*. 2020; 26(2): 187-191.

^{ix} Honore P, Lamprecht L, Stefanak M. An examination of public health financial management system accreditation standards. *J Health Care Finance*. 2016;43(2):210-224.

^x Carlson V, Chilton MJ, Corso LC, Beitsch LM. Defining the functions of public health governance. *Am J Public Health*. 2013; 105(2):S159-S166.

^{xi} Public Health Accreditation Board. (2021). What is public health department accreditation? <https://phaboard.org/what-is-public-health-department-accreditation/>

^{xii} Nguyen TH, Shah GH, Schwartz RD, Jones JA. Factors associated with continuous improvement by local boards of health. *J Public Health Manag Pract*. 2019;25(5):415-422.

^{xiii} Newman SJ, Leep CJ. A look at local public health governance: findings from the 2015 Local Board of Health National Profile. *J Public Health Manag Pract*. 2016;22(6):609-611.

^{xiv} Boedigheimer SF, Yeager VA, Chapple-McGruder T, Moffatt S, Halverson PK. Public health senior deputy's perceptions of state health officials' success factors: professional characteristics, personal attributes, and signs of derailment. *J Public Health Manag Pract*. 2020;26(1):16-22.

^{xv} Caron RM, Hiller MD, Wyman WJ. Public health system partnerships: role for local boards of health in preparing the future public health workforce. *J Community Health*. 2014;39(1):29-34.