Understanding Small Local Health Departments and the Enablers of Accreditation among these Agencies

Report

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Introduction

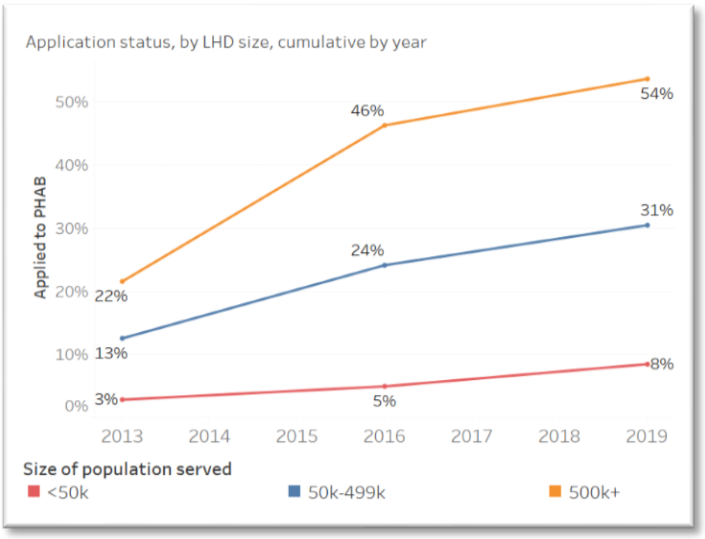
Early studies of Local Health Department (LHD) participation in national voluntary accreditation showed that larger LHDs, those agencies serving larger populations and with more full time employees, were more likely to intend to participate in accreditation, to initiate the accreditation process, and to get accredited.[1,2] Studies of LHDs consistently highlighted the following accreditation barriers: the time and effort required of accreditation exceeds the perceived benefits, the accreditation fee, and accreditation standards exceed perceived LHD capacity.[3,4] Other studies found a relationship between specific LHD characteristics and the likelihood to participate in or gain accreditation. More specifically, LHDs that had quality improvement strategies or a formal quality improvement program in place as well as those with higher levels of governance from a board of health were associated with a greater likelihood of seeking and being accredited.[2,5,6] Despite the fact that evidence shows trends toward more quality improvement among LHDs over time, the number of small LHDs that are participating in accreditation remains low. Seven years after the first health departments were accredited, small LHDs are less likely to participate in accreditation than larger LHDs. As of October 2019, 455 health departments in the US had applied for accreditation, with 126 of those being small LHDs. Thirty-six small LHDs had submitted independent applications and been accredited by the Public Health Accreditation Board (PHAB). Another twenty-six were accredited as part of a centralized state's accreditation process. These small LHDs are a fraction of the small LHDs in the U.S. Based on numbers alone, they are outliers, and insight from their experiences may help other small LHDs considering accreditation. The purpose of this work was to examine small LHD accreditation. In particular, we review application trends and explore factors that enable small LHD accreditation.

Methodology

This project included quantitative and qualitative analyses. For the purposes of this study, small LHDs include those LHDs serving populations of less than 50,000 people. The quantitative analyses included trend analysis and latent class analysis. PHAB data was used in conjunction with NACCHO Profile data to characterize aspects of small LHDs as they relate to accreditation. The qualitative component included interviews with leaders and accreditation coordinators among accredited small LHDs.

Overview of Application Trends

The percent of small LHDs that applied for accreditation is increasing over time: 3% by 2013, 5% by 2016, and 8% by 2019. However, despite being the largest group of health departments nationally, small LHDs lag behind mid-sized LHDs (serving populations of 50,000-499,000) and large LHDs (serving 500,000+), of which 31% and 54% applied to PHAB by 2019, respectively.

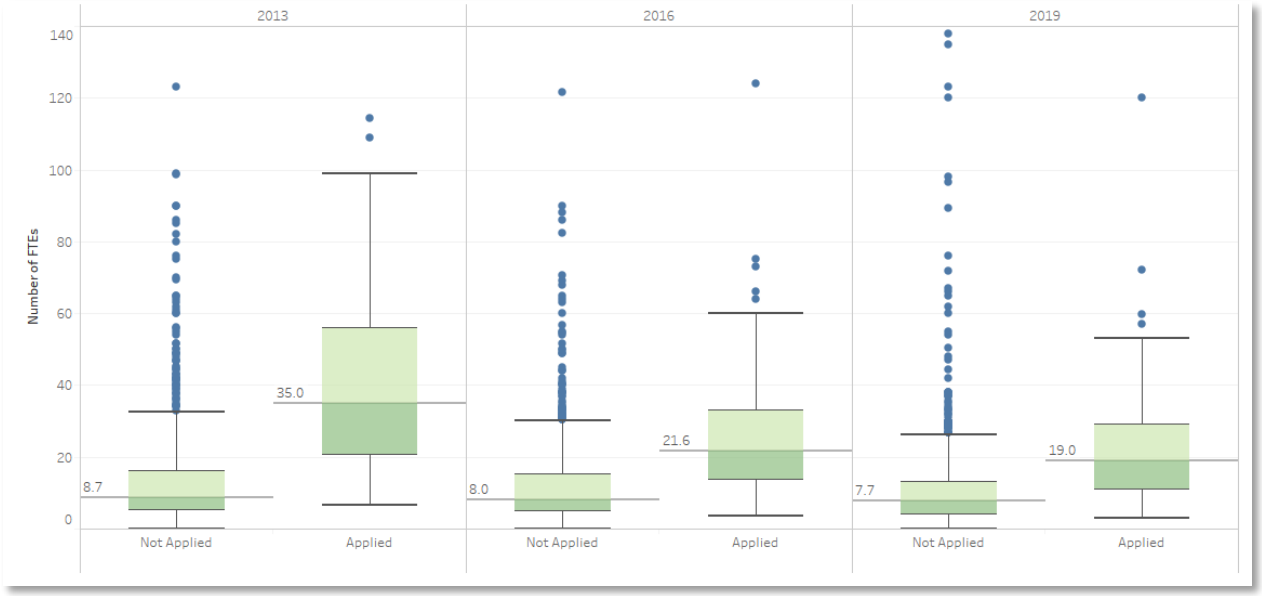


Uptake from small local health departments is particularly low when accounting for the impact of statewide initiatives. The state of Florida was accredited as a centralized system, accounting for 20% percent of all small LHDs that had applied as of 2019. Similarly, a statute in Ohio required all LHDs to apply for accreditation by 2018; these account for another 44% percent of all small LHDs that had applied as of 2019. This leaves approximately 45 small local departments that had applied independently of these state-based initiatives.

Characteristics of small LHDs that had applied to PHAB versus those that had not

Among those small LHDs that applied in 2013 compared to those that had not, a significant difference was observed in both expenditures and staffing. Overall, small LHDs that had applied to PHAB by 2013 spent $90 per capita on median, compared to $38 per capita on median for those that had not applied. By 2019, this had narrowed to $66 per capita among those that had applied, compared to $39 per capita among those that had not. Similarly, it appears that small LHDs with more FTEs applied at higher rates through 2013, with median FTE at 35, compared to 9 on median for agencies that had not applied. This narrowed somewhat by 2019, with median FTE size for small LHDs that had applied at 19 FTE, compared with 8 FTE among the small LHDs that had not applied.

Figure 2: Box plot of FTE size, by year and application status



A difference in activity/service provision was also observed between small LHDs that applied and those that did not across all years. The NACCHO Profile asks agencies to indicate what types of services they directly provide, what is contracted out, what is provided by others, and what is not available in the community. Among those small LHDs, LHDs that did not apply reported directly providing a median of 15 nonclinical services and activities in 2019, compared to 22 nonclinical services and activities among small LHDs that did apply.

Figure 3: Count of activities, by year, among small LHDs

Note: Excludes Florida LHDs and DC

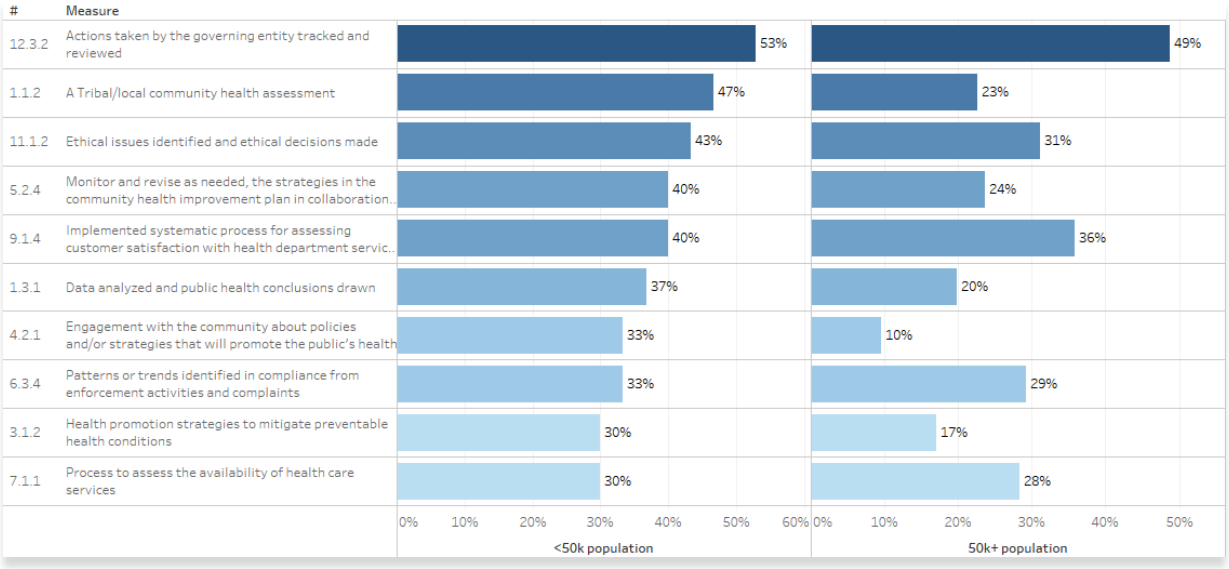
Considering Action Plan status as a measure of need

As part of the accreditation process, there are multiple points for feedback. Applying local health departments that do not satisfactorily meet some of the requirements may receive an 'Action Plan,' indicating what will need revision before proceeding to accreditation. Overall, 34% of health departments that applied in 2013 had an action plan. This included 47% of small local health departments, 36% of mid-sized health departments, and 18% of large health departments. The proportion of local health departments that had applied through 2016 receiving an action plan increased to 43% overall and 62% for small LHDs. This may be in part attributable to the implementation of the new PHAB 1.5 standards, and might also be related to Ohio local health departments that began applying after the accreditation requirement went into to statute.

Assessments on the measures also differs by health department size, as the Figure shows below, with the largest differences from larger LHDs included Measures 1.1.2 (A tribal/local community health assessment, 47% assessed as Not/Slightly Demonstrated vs 23%); 11.1.2 (Ethical issues identified and ethical decisions made, 43% vs 31%); 5.2.4 (Monitor and revise as needed the strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners, 40% vs 24%); 1.3.1 (Data analyzed and public

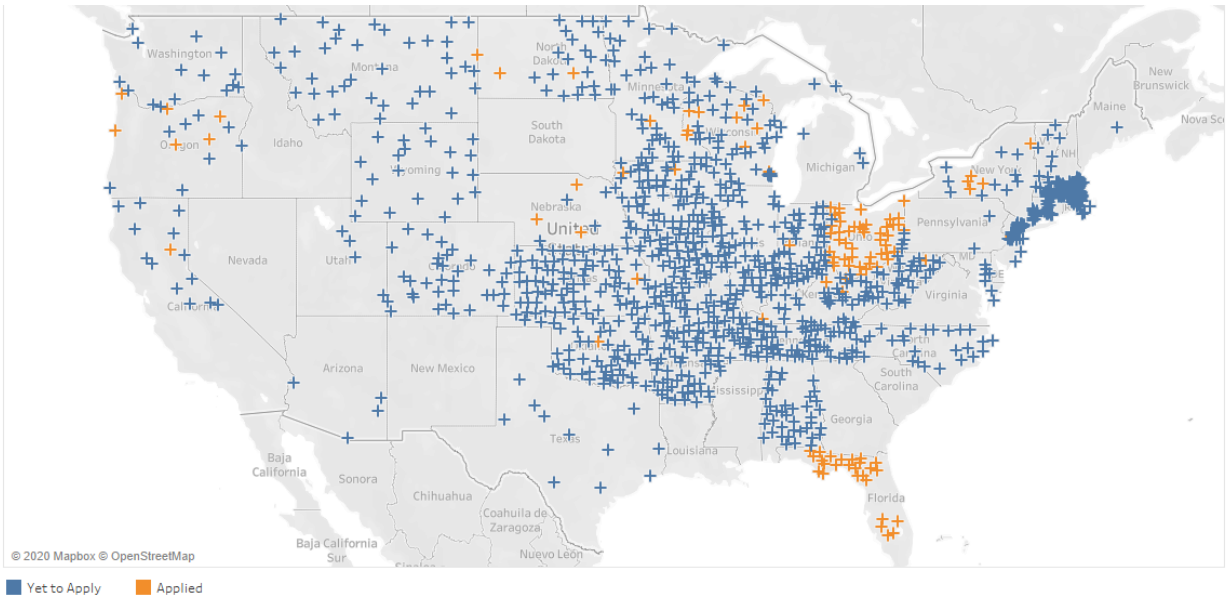
health conclusions drawn, 37% vs 20%); and 4.2.1 (Engagement with the community about policy and/or strategies that will promote the public's health, 33% vs 10%).

Figure 4: Percent of applications receiving Not/Slightly demonstrated by measure item and size

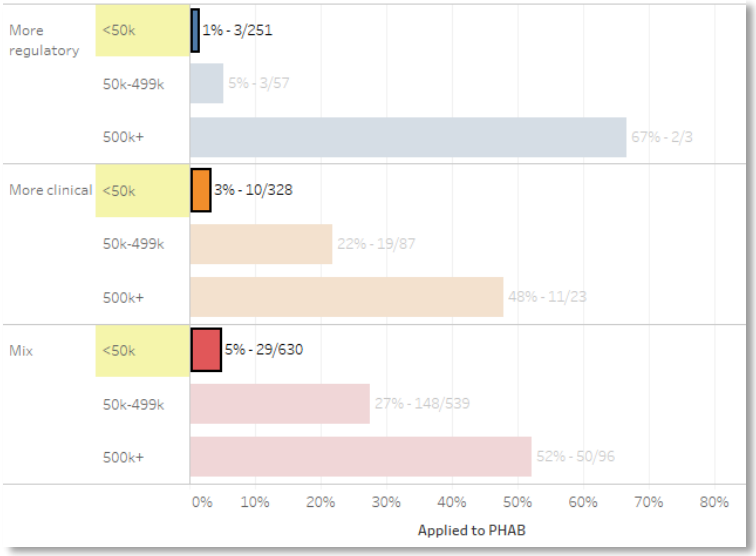


Note: As of December 2019

Figure 5: Considering the 'market' for small LHD accreditation across the US



Local health departments serving fewer than 50,000 people represent approximately 59% of all LHDs in the US that have yet to apply for PHAB accreditation. To better understand how local health departments might have different motivations and barriers to accreditation by virtue of their organizational structure, we conducted a Latent Class Analysis using activity/service counts by LHDs to classify them into groups. Among small LHDs that performed relatively more inspection/regulatory activities ('more regulatory'), application to PHAB is extremely low, about 1%. Among small LHDs that are relatively 'more clinical,' applications are at about 3% nationally. Among small LHDs that have more of a mix of services, applications are at 5% nationally. Small agencies that are more regulatory in nature are largely clustered on the east coast (New Jersey, Massachusetts, Connecticut) and the Midwest (Indiana). Small LHDs that are relatively more clinical are clustered in the Midwest, and 'mixed' LHDs are largely clustered in the South.



Note: Excludes LHDs from OH and FL

Qualitative Interview Insights

We conducted key informant interviews with representatives from 9 accredited small LHDs. Participant LHDs were selected to include geographically diverse regions of the US, variation in size within small LHDs, LHDs with and without action plans, and LHDs with and without board involvement. We also included two LHDs that were known to have received some external funding to support their accreditation process. LHDs included at least one representative from each of the types of governance structures: centralized, decentralized, and shared governance. All LHDs that were invited agreed to participate in a qualitative interview.

Accreditation Motivation

The most common motivator (among 7 of 9) to being accredited was the expectation that health departments would eventually be required to be accredited in order to qualify for certain types of funding or that it would provide an advantage for future grant applications. None of the respondents reported that this anticipated advantage has been realized to date. Other motivators among at least half of respondents included that the state encouraged/facilitated accreditation; the LHD was already doing many activities that are required (e.g., CHNA, Strategic Plan, etc.); the LHD had a champion encouraging accreditation or had strong leadership support for accreditation; and LHD leaders believed that accreditation would help the LHD improve workforce development/continuing education.

Accreditation Facilitators

The most commonly noted facilitators for accreditation included: having flexible dollars or a county tax fund to cover the PHAB accreditation fee; having enough money and being able to fund a full-time person that was hired specifically for accreditation; having a formalized process or being highly organized (e.g., meeting agendas and action items, documentation cover pages, standardized online folder system, leadership-only finished document folder, etc.); collaborating with academics and other small LHDs; and focusing early on communicating with staff in order to *gradually* get buy-in toward participating in the accreditation process.

Other facilitators included having state provision of a related training; employing domain teams with domain champions (having all staff involved in some way); conducting pre-accreditation preparation and/or an extensive review of PHAB expectations; and creating a fun/competitive environment for the domains (e.g., team handshakes, songs, etc.). In a couple cases, external support via other community partners, an existing community health coalition, or volunteers were helpful to completing the accreditation process.

Accreditation Challenges

Accredited small LHDs reported challenges they experienced during the accreditation process. Perhaps most important, because this challenge can potentially be addressed, was that

participants noted it was challenging to not have examples of documents appropriate for small LHDs to include in the accreditation submission. Challenges that were noted but are more difficult for PHAB to address include competing priorities within the organization and finding the funds to cover the accreditation fee. Another barrier that was noted that has the potential to be influenced is that health departments are uncertain if they can be successful in the accreditation process and that uncertainty serves as a barrier to getting started. Lastly, respondents discussed the challenge of partnering with hospitals on accreditation activities, specifically for CHNAs, when PHAB accreditation requires CHNAs within five years but federal tax policy requires hospitals to conduct CHNAs ever three years. Respondents felt that partnering with hospitals to conduct a CHNA every three years was too burdensome.

Recommendations to other LHDs from interview participants

The following recommendations were offered to support other small LHDs in getting accredited:

- All plans should all align (while this didn't make sense to small LHDs at first, it was reported that this was a key to success)
- Front-loading: do an extensive review of PHAB expectations and as much preliminary work as possible to prepare before hitting the 'apply' button
- Have a good record keeping system (e.g., meeting minutes, online file organization, leadership-only finished document folder, etc.)
- Work with partners, especially those who can share examples of documents
- Have a staff person train as a PHAB site visitor, if possible

Conclusion

Public health accreditation among small LHDs in the United States is still somewhat uncommon and the largest groups of small LHDs that have been accredited have come through state-based initiatives. This report identified several considerations and recommendations for small LHDs considering pursuing accreditation. Recognition that small LHDs are similar, but not monolithic, is critical. Small LHDs may be composed around providing inspection and regulatory services, more clinically-oriented services, or a mix of both. That service mix likely directly affects the

incentives and abilities of LHDs to apply for accreditation. Additionally, though the difference has narrowed over the past six years, better resourced and staffed LHDs are applying in higher proportion. As such, providing greater support to smaller agencies may be prudent.

PHAB may consider offering more directed guidance, especially around having examples of appropriate documents relevant for small LHDs. Providing a repository of appropriate examples for different LHDs (by size and by common activities) would likely support LHDs in their accreditation readiness and reduce this barrier. Such examples may provide LHDs with information that they can use to prepare in advance to apply and might lead to having the confidence to apply.

References

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