Accreditation: On target

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Commentary
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In its 2002 update on public health titled *The Future of the Public’s Health in the 21st Century*, the Institute of Medicine recommended the following:

The Secretary of DHHS should appoint a national commission to consider if an accreditation system would be useful for improving and building state and local public health agency capacities. If such a system is deemed useful, the commission should make recommendations on how it would be governed and develop mechanisms (e.g., incentives) to gain state and local government participation in the accreditation effort. Membership on this commission should include representatives from CDC, the Association of State and Territorial Health Officials, the National Association of County & City Health Officials, and nongovernmental organizations.1

This recommendation was in response to a finding:

Although the health care delivery system has several mechanisms for accreditation and quality assurance, the committee found that there are no such structures for the governmental public health infrastructure. Accreditation mechanisms may help to ensure the robustness and efficiency of the governmental public health infrastructure, assure the quality of public health services, and transparently provide information to the public about the quality of the services delivered.1

Ten years ago, representatives from our organizations (the National Association of County & City Health Officials, the American Public Health Association, the National Indian Health Board, the National Association of Local Boards of Health, and the Association of State and Territorial Health Officials) and others set out to determine whether such an accreditation system was feasible from a business perspective, practical from a programmatic perspective, and desirable. As representatives from these 5 organizations, we worked with a national steering committee, comprising a broad group of stakeholders including public health practitioners, funders, and partner organizations, to sort out the many dimensions of such a program. The group explored the following key questions: (1) What are the pros and cons of doing it? (2) How should it be paid for? (3) What are the challenges in implementation? (4) How should an accreditation program address the huge variance in capacities, staffing size, and resources of state and local health agencies? and (5) Should the system be voluntary or mandatory? There were both significant concern and support from a range of stakeholders along the way. However, a transparent and inclusive process that ensured substantial stakeholder representation and input every step of the way resulted in a final proposal that recommended that the field adopt a voluntary accreditation system for public health
departments. We now have solid proof of our collective, original concept.

We looked back at the Final Recommendations for a Voluntary National Accreditation Program (available at: http://www.phaboard.org/wp-content/uploads/ExploringAccreditationFinalRecommendations.pdf), the report from the group whose spirited discussion conceived the conceptual framework for a national program, and examined current operations of the Public Health Accreditation Board (PHAB). According to the report, a national program was desirable because it would present an opportunity for continuous quality improvement, accountability, consistency, excellence, standardized expectations for performance, brand identity, visibility, and credibility of governmental health departments while ultimately contributing to efforts to improve the public’s health. The group believed that it would be feasible because, along with application fees to support the costs of the program, at least 1 major national foundation, the Robert Wood Johnson Foundation, and the Centers for Disease Control and Prevention had sufficient interest to subsidize the activity’s development and operations. In addition, some states already had programs in place and, over time, coordination with them seemed possible.

The early-adopter vanguard among the nation’s tribes, territories, and local and state health departments have expressed interest in national accreditation in several ways. At press time, 2 state health departments and 17 local health departments have been accredited; 16 more state health departments, 115 additional local health departments, and 1 tribal nation have indicated formal interest in accreditation, with some lesser numbers of these departments having submitted materials for review.

● A Look Back

While the details of implementing national accreditation were intentionally left to those who would take on the challenge of developing the accrediting entity, PHAB’s organization and processes comport with the original vision in the 8 prominent areas of the initial report.

● Governance

A new nonprofit organization has been established, independent of the departments being accredited, which is responsible for orienting applicants to the accreditation process and conducting it but does not generate revenue from anything other than the accreditation process itself. The organization adopts standards and criteria, makes accreditation decisions, and applies an independent program of research to test the hypothesis that a national accreditation program achieved the goals established for it. The organization’s governing board comprises representatives from local and state health departments, tribal nations, academia, health care organizations, federal government, and governing boards of health departments. As ex officio members of the board, the founding organizations (the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County & City Health Officials, and the National Association of Local Boards of Health) have been augmented with a representative from the National Indian Health Board. State-based accreditation programs continue to operate in parallel with PHAB, with each learning from one another and complementing each other’s work. Throughout the development of PHAB, and continuing into the current era of accrediting health departments, the applicants’ peers participate in the review process and are represented on the panel that makes final decisions about accreditation. This is not a case of others imposing standards and measures on the practitioners; its success is rooted in the inclusiveness of the process.

● Eligible Applicants

The governmental agency with the primary statutory responsibility for public health at the local, tribal, state, or territorial level is eligible for accreditation. Not originally recommended, accommodation has been made to recognize the special nature of centralized public health agencies where local health departments are part of state government. Multijurisdictional arrangements among health departments can be recognized.

● Standards Development

Initial standards address process and capacity. PHAB has employed “think tanks” to inform its process for reaching final decisions about standards, eligibility, and process. Small groups with special expertise in an area meet with support from PHAB staff to wrestle with challenging issues (eg, how to strengthen attention to issues of health equity through the standards, how to best align public health preparedness metrics with PHAB standards and criteria; how to address variation based on tribal or territorial status).2

The Operational Definition of a Functional Local Health Department along with the National Public Health Performance Standards and documentation from several state accreditation programs served as the initial
bases for PHAB standards. Although domains focused on health department governance and administration were added to those focused on the 10 Essential Public Health Services, program-specific standards are, currently, outside the scope of the national program. However, documentation from programs may be used to demonstrate that measures have been met. PHAB recently announced a first set of revisions to its standards based upon its initial experience with the actual accreditation process and suggestions from practitioners to add or give emphasis to emerging issues. This version of standards and criteria (version 1.5) will take effect on July 1, 2014. As PHAB gains more experience in managing accreditation and as promising practices change, PHAB will develop a definitive cycle for the revision of standards and measures. Thus, standards are now being updated regularly, sensitive to state, tribal, territorial, and local conditions, and will continue to be. It is uncertain whether one of the original recommendations that standards should not place health departments in a position of violating jurisdictional law has been discussed or reviewed by PHAB.

● **Conformity Assessment**

Consistent with the original vision of operations, PHAB staff provide training to applicants to ensure that they have a consistent and complete understanding of how the process works and what to expect. Entities seeking accreditation submit letters of intent to allow PHAB to forecast demand for staff and volunteer site visitors. Applicants complete an application and submit confirmation from the department’s governing board supporting the application and accreditation prerequisites: a comprehensive community health assessment, community health improvement plan, and agency strategic plan. The crux of the accreditation process is documentation supporting the agency’s conformity with standards and measures. Documentation is reviewed by a site visit team, comprising trained peers, and results in a report that is used by an Accreditation Committee to determine accreditation status. The decision of the committee is subject to appeal.

● **Financing**

A PHAB committee recommended initial fee levels to be paid by applicants. Recognizing that affordability was critical to success, federal and foundation funders have supported and subsidized initial start-up costs and application fees. In the long-term, PHAB’s operations are still projected to be self-sustaining, designed leanly to keep costs low for applicants.

● **Incentives**

As described by Thielen et al, there are many benefits and potential incentives for health departments to become accredited: national recognition, the opportunity to engage the workforce in quality improvement, access to public health experts, potential access to new funding streams, potential streamlining of grant reporting, and participation in the development of a strong database of best practices.

Foundation and federal funding have been made available to offset the cost of fees and to support the cost of staff in some state and local governments who devote time to preparing their departments for accreditation. Funds have been made available to several national associations that work closely with eligible departments to provide technical assistance and share materials and experiences of those preparing for and experienced with the accreditation process. Communities of practice have assembled within states and, nationally, to share both state and local experiences and documentation materials. What is not certain is whether being accredited by PHAB will substitute for other quality assurance processes that may be required by states or federal policy makers. One wonders, too, whether incentives, positive or not, will be adopted by funders and policy makers to alter the truly voluntary nature of the present accreditation process.

● **Evaluation**

PHAB has formally adopted a research agenda and actively seeks outside evaluation of the accreditation program. Evaluation will support and improve program and process effectiveness, customer satisfaction, appropriateness of standards and criteria, and the credibility of the accrediting program—all areas related to understanding the long-term utility of national accreditation.

As former members of the Exploring Accreditation Steering Committee and as ex officio members of PHAB, we are pleased to say that the board charged with “standing up” what we now know as PHAB has been true to the recommendations made in 2006. The experiment to test whether national accreditation of local and state health departments is truly desirable and feasible and will deliver on its promised outcomes has now begun.

It is also time to think about what else seems impossible but may turn out to be possible: a public health platform for health information exchange closely linked to the networks now being established among
those providing health care? A uniform chart of financial accounts among local and state health departments? A well-defined minimum package of essential public health prevention and clinical services available to the entire population along with the funding, technology, and staff to support those important services and ensure their excellence? A nation and its states and local communities committed to achieving health, equity, and security, full adoption of experience and evidence-informed practices and continuously improving outcomes in the clinical and public health domains, better balanced investments in public health and clinical research, and adoption of a health-in-all-policies framework where we live, learn, earn, yearn, and play?

REFERENCES