Legal Frameworks Supporting Public Health Department Accreditation:

Key Findings and Lessons Learned from Ten States

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Table of Contents

Introduction .................................................................................................................................................. 3
Methods ....................................................................................................................................................... 4
Findings ....................................................................................................................................................... 5-16
   Table 1. Case Study States ....................................................................................................................... 6-8
   Key Findings .......................................................................................................................................... 9-12
   Discussion: Legal and Policy Lessons Learned ................................................................................... 13-15
   Additional Resources ............................................................................................................................ 16
   Conclusion ........................................................................................................................................... 17
Case Studies ............................................................................................................................................... 18-39
   Illinois: Local Health Department Certification Program ................................................................. 19-20
   Iowa: Voluntary Accreditation Program ................................................................................................. 22-22
   Kansas: Regional Cooperation and Quality Improvement .................................................................... 23-24
   Michigan: Local Public Health Accreditation Program .................................................................... 25-26
   Missouri: Voluntary Local Public Health Agency Accreditation Program ..................................... 27
   Montana: Pilot Project for Implementing National Public Health Standards .................................... 28-30
   New Hampshire: Public Health Improvement Action Plan ..................................................................... 32-33
   North Carolina: Local Health Department Accreditation Program ............................................... 34-36
   Oklahoma: Step UP Performance Management System ....................................................................... 37-38
   Wisconsin: Local Health Department Review Process ....................................................................... 39-40
Table 2. Results of Mapping Study ........................................................................................................... 41-42
Endnotes .................................................................................................................................................... 43-45
Introduction

The accreditation of public health departments is expected to play a significant role in strengthening the performance, effectiveness, and accountability of the nation’s public health system. After extensive study, a national voluntary accreditation program has been endorsed by leading public health organizations, including the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH).

The Public Health Accreditation Board (PHAB) was incorporated in 2007. With support from the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention (CDC), PHAB has been working with public health experts to develop a national voluntary accreditation program for state and local public health departments. In 2009 – 2010, 30 state, local, and tribal health departments (“beta test sites”) piloted the full accreditation process and provided feedback to PHAB. The program is now set to launch in fall 2011. PHAB’s goal is to have 60% of the US population served by an accredited public health department by 2015.1

In 2010-2011, the North Carolina Institute for Public Health conducted a study of state legal frameworks supporting public health department accreditation or related programs (e.g., certification, performance management, quality improvement). First, a mapping study of 23 states was conducted to identify current programs and their legal frameworks (see Table 2). Ten states were then selected for in-depth study. These states are Illinois, Iowa, Kansas, Michigan, Missouri, Montana, New Hampshire, North Carolina, Oklahoma, and Wisconsin. While all ten states are planning to participate in the national program, they approach accreditation from a variety of starting points. Some have mandatory accreditation programs based in statute, while others operate voluntary performance management or quality improvement programs. Still others are experimenting with regional cooperation (through interlocal agreements) as an approach to accreditation and/or quality improvement.

This report presents the results of the study, with the hope that the research findings and legal lessons learned from these ten diverse states will be of benefit to other states as they prepare to participate in the national voluntary accreditation program.

“Accreditation is a major accomplishment for a health department. It means that it is addressing key community health problems. Just as the public expects hospitals, law enforcement agencies and schools to be accredited, so should they come to expect health departments.”

–CDC Director Thomas R. Frieden
Methods

Data was collected in two phases. In the first phase, the research team conducted semi-structured interviews with public health practitioners in 23 states to identify the type of program currently in existence in the state (accreditation, certification, performance management, quality improvement, other) and the legal framework supporting it. In addition, legal and policy documents were collected from interviewees and online sources. Sixteen states were selected for the mapping study based on their participation in the Multi-State Learning Collaborative (MLC), funded by the Robert Wood Johnson Foundation, which focused on accreditation and quality improvement. An additional seven states were selected for the mapping study based on their identification by ASTHO and/or NACCHO as states involved in accreditation and/or quality improvement.

In the second phase of data collection, ten states were selected from among the original 23 to participate in case studies. Selection as a case study state was limited to those states actively preparing to participate in the national voluntary accreditation program. Secondary selection criteria aimed at obtaining diversity among case study states with regard to 1) the type of legal framework (policy, regulation, statute) currently supporting accreditation or a related program; 2) whether the current legal framework is based on broad or specific legislative authority; 3) whether accreditation or related efforts rely on recently-updated or long-standing legislative provisions; and, 4) geographic location within the US.

Semi-structured interviews were conducted with public health practitioners and other stakeholders involved with accreditation or related programs in each case study state (2 – 6 interviews per state). Interviewees included current and former state and local public health officials (including state public health attorneys), as well as representatives of state public health institutes, associations of counties, associations of local health departments, associations of public health officials, and private legal consultants.

 Relevant legal and policy documents were collected from each state, as well as educational materials and formal and informal program-related documents, such as program descriptions, guides, and fact sheets.

For each state, a case record was created which included transcribed interviews and related documents. Case records were analyzed to identify unique and cross-cutting themes related to legal issues and lessons learned regarding the development of state-based accreditation and related programs. In addition, case records were analyzed to identify legal issues related to participation in the national voluntary accreditation program.
Findings
Table 1: Case Study States

<table>
<thead>
<tr>
<th>State</th>
<th>Organization of Public Health System*</th>
<th>Current State Program</th>
<th>Legal Framework</th>
<th>Approach to PHAB Accreditation</th>
<th>Legal Strategies for Achieving PHAB Accreditation</th>
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| IL    | Illinois Department of Public Health (IDPH) has a shared/mixed relationship with the state’s 95 LHDs | Illinois Local Health Department Certification Program (launched 1993) | • Certification is based in statute: 55 ILCS 5 authorizes IDPH to establish minimum standards; specific regulations are found in Illinois Administrative Code Title 77, Section 600  
• Certification is awarded by IDPH  
• LHD participation in the certification program is voluntary, but certification is an eligibility requirement for Local Health Protection Grants awarded by IDPH | • Recommendation for LHDs to participate in PHAB accreditation as an alternative to IL certification  
• Decided against developing state accreditation program | • Considering a mechanism under the existing regulatory framework to recognize accreditation by PHAB as satisfying Illinois certification requirements |
| IA    | Iowa Department of Public Health (IDPH) has a decentralized relationship with the state’s 101 city, county and regional LHDs | Iowa Voluntary Accreditation Program (established 2009 with launch date of 2012) | • Accreditation is specifically authorized by statute: Ch. 135A: Public Health Modernization Act of 2009  
• IDPH will administer the program with the accrediting body to be determined by the Public Health Advisory Council  
• LHD participation is voluntary | • IDPH plans to apply for accreditation | • New statute permitting district health departments  
• IDPH plans to seek equivalency with PHAB accreditation |
| KS    | The Division of Health of the Kansas Department of Health and Environment (KDHE), has a decentralized relationship with the state’s 100 single and multi-county LHDs | Regional cooperation and quality improvement efforts are currently underway in Kansas | • Quality improvement is by KDHE policy  
• Quality improvement projects are being led by the Kansas Health Institute, Kansas Association of Local Health Departments, and the Kansas Department of Health and Environment  
• LHD participation is voluntary | • Studying regional accreditation | • Regional cooperation via interlocal agreements under KSA 12-2901 et seq. |
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| MI    | Michigan Department of Community Health (MDCH) has a decentralized relationship with the state’s 45 city, single county, and multi-county LHDs | Michigan Local Public Health Accreditation Program (established 1996; launched 1999) | • Accreditation is based in statute: MCL 333.24729 directs MDCH to establish minimum standards (Act 368 of 1978, Public Health Code); MDCH policy (Policy 8000) outlines the principles governing the development and adoption of minimum program requirements  
• MDCH is the accrediting body with daily operations handled by the Michigan Public Health Institute  
• LHD participation is mandatory | • No plans to seek equivalency from PHAB  
• Will maintain existing state accreditation program after PHAB launch | • Legal/policy environment allows LHDs to apply for national accreditation if they desire |
| MO    | The Division of Community and Public Health of the Missouri Department of Health and Senior Services (MDHSS), has a decentralized relationship with the state’s 115 LHDs | Missouri Voluntary Local Public Health Agency Accreditation Program (launched 2003) | • The accreditation program operates independent of state laws, regulations, and policies  
• The Missouri Institute for Community Health (MICH), a nonprofit agency, is the accrediting body  
• LHD participation in voluntary | Decision pending whether to continue state program  
• MDHSS & some LHDs plan to apply for accreditation | • Legal/policy environment allows LHDs to apply for national accreditation if they desire |
| MT    | The Montana Department of Public Health and Human Resources (MDPHHS) has a decentralized relationship with the state’s 52 LHDs | Pilot Project for Implementing National Public Health Standards (launched 2009) | • The pilot project is by statute (HB 173) (2009)  
• MDPHHS is administering the project  
• LHD participation is voluntary | MDPHHS & some LHDs plan to apply for PHAB accreditation | • Legal/policy environment allows LHDs to apply for accreditation if they desire |
| NH    | The Division of Public Health Services (DPHS) of the New Hampshire Department of Health and Human Services has a decentralized relationship with the state’s 2 LHDs | New Hampshire Public Health Improvement Action Plan (released 2008) | • The plan was developed by the Public Health Improvement Services Council which is responsible for monitoring its implementation  
• The Public Health Improvement Services Council is a legislatively enacted body (HB 491) (2007) | DPHS and 2 LHDs plan to apply for PHAB accreditation | • Uncertain legal status of Regional Public Health Networks for PHAB accreditation |
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| NC    | The Division of Public Health (DPH) of the North Carolina Department of Health and Human Services has a decentralized relationship with the state’s 85 single county and multi-county LHDs | North Carolina Local Health Department Accreditation Program (established 2005; launched 2006) | • Accreditation is specifically authorized by statute: NCGS 130A-34.1 (2005); regulations were developed in 2006 (10A NCAC 48A)  
• An independent Accreditation Board is established by 130A-34.1; the NC Institute for Public Health at the UNC Gillings School of Global Public Health administers the accreditation program  
• LHD participation is mandatory | • DPH plans to apply for accreditation | • DPH plans to seek equivalency with PHAB accreditation |
| OK    | Oklahoma State Department of Health (OSDH) has a shared/mixed relationship with the state’s 68 centralized LHDs and 2 independent city-county LHDs | Step UP Performance Management System (launched 2008) | • Performance management is by state health department policy  
• Step UP is administered by OSDH  
• LHD participation is mandatory | • OSDH & independent city-county LHDs plan to apply for PHAB accreditation, with other LHDs to follow | • Legal/policy environment allows LHDs to apply for national accreditation if they desire |
| WI    | The Division of Public Health (DPH) of the Wisconsin Department of Health Services (WDHS) has a shared/mixed relationship with the state’s 92 county and municipal LHDs | Wisconsin Local Health Department Review Process (launched 1998) | • The Review Process is based is statute: Chapter 251.20 (1993) directs WDHS to specify required services; specific regulations are found in administrative code: Chapter DHS 140 (1998)  
• The Review Process is administered by DPH; LHD level is awarded by the state health director  
• LHD participation is mandatory (there are 3 levels of LHDs, all LHDs must achieve a minimum of Level I) | • State health plan calls for all LHDs to be accredited using national standards by 2020 | • Planned revisions to DHS 140 to incorporate some PHAB standards  
• May recognize LHDs accredited by PHAB as meeting Review requirements |

*Association of State and Territorial Health Officials (ASTHO). Profile of State Public Health: Volume One. Available at: http://www.astho.org/Display/AssetDisplay.aspx?id=4078. Definitions: Centralized = State health agency provides local services; Decentralized = Local health departments are organizationally independent of the state health agency; Shared/mixed = Combination of centralized and decentralized.
Key Findings

This section presents the key findings of the study. First, the legal frameworks supporting current state-based accreditation and related programs in the ten case study states are summarized. Second, the impact of the national voluntary accreditation program on these legal frameworks is examined. Third, findings related to shared service delivery as an approach to accreditation are summarized. Finally, suggestions from case study states as to how the federal government might incentivize participation in the national accreditation program (through the legal terms and conditions of various funding mechanisms) are discussed.

I. Legal Framework of Current State-Based Accreditation and Related Programs

- As illustrated in Table 1, the ten case study states are approaching the national accreditation program from a variety of starting points:
  - Iowa, Michigan, Missouri and North Carolina have state accreditation programs; two of which are mandatory for LHDs. Of these four programs, three are based in statute, while one is operated by a nonprofit organization independent of state laws, regulations, or policies.
  - Illinois has a voluntary certification program based in statute and regulation; however, certification is an eligibility requirement for state local health grants.
  - Wisconsin has a regulatory “review process” which operates similarly to certification. The process is mandatory for LHDs and based in statute and regulation.
  - The four remaining case study states are engaged in quality improvement processes. Kansas is examining shared service delivery (often based in interlocal agreements) as a way to improve quality through regional cooperation. Montana is implementing national standards through a legislatively-enacted pilot project. New Hampshire is monitoring the implementation of a public health improvement action plan through a special council created by the state legislature. Oklahoma is administering a mandatory performance management system through state health department policy.

- Public health agency attorneys and private attorneys (consultants) were involved in creating the legal frameworks for these programs in six of the ten case study states.

II. Impact of National Accreditation Program on Current Legal Framework

- All ten case study states are planning to participate in the national voluntary accreditation program, although to varying degrees.
Because the national program is voluntary, no states anticipate significant barriers in their laws, regulations, or policies that will prohibit or hinder participation. Minor conforming amendments or technical changes may be needed in some states.

At least five of the six states with accreditation or certification programs (Illinois, Iowa, Michigan, North Carolina, and Wisconsin) plan to maintain their state program after the national voluntary accreditation program is launched. Their plans at the time of this study are indicated below.

- Iowa and North Carolina may seek to have their state program “deemed equivalent” to the national voluntary accreditation program by PHAB. In this case, no changes to state laws, regulations, or policy are anticipated.

- Illinois and Wisconsin are considering the reverse – the state health department would recognize a LHD that is accredited by PHAB as having met the requirements of their state program. In these states, some conforming modifications to relevant state laws, regulations, or policy may be needed in order to acknowledge accreditation by PHAB as satisfying state requirements. However, these states noted that no modifications can be made until the national program is officially launched.

- Michigan plans to run their mandatory accreditation program alongside the national voluntary program. LHDs in this state would be required to participate in the state program, and could, if desired, also seek accreditation by PHAB.

- Missouri, whose program is run by a nonprofit agency independent of state law, regulation, or policy, is grappling with the question of whether or not it makes sense to run a voluntary state program alongside a voluntary national program.

- The remaining four case study states (Kansas, Montana, New Hampshire, and Oklahoma) are not planning to create new state-based accreditation or certification programs.

### III. Shared Service Delivery as an Approach to Accreditation

- Shared service delivery among two or more local health departments (LHDs) is one approach to accreditation for LHDs that cannot meet all standards on their own. There is a wide spectrum of options for shared service delivery ranging from informal agreements to consolidation of health departments into a district.

- In some states, shared service delivery is viewed neutrally or positively by LHDs. In Kansas, shared service delivery arrangements fall in the middle of the spectrum and generally involve interlocal agreements where LHDs retain their autonomy.
o In other states, many LHDs fear that shared service delivery will lead to consolidation (i.e., merging of LHDs into a district or regional health department) and loss of local autonomy and resources.

IV. Funding Accreditation

- Many interviewees reported concerns about how state and local health departments will meet costs associated with PHAB fees and accreditation preparation activities (e.g., carrying out a community health assessment, developing a community health improvement plan, gathering documentation).

- Case study states indicated they had few resources to assist LHDs with accreditation costs. While technical assistance could be provided by most states, only two states indicated funds were available to assist LHDs with preparation activities.

- Several interviewees indicated that they believed accreditation might eventually become an eligibility requirement for federal funding.

- To assist state and local agencies with these costs, several suggestions related to the legal terms and conditions of federal assistance mechanisms were made by interviewees:
  
  o With regard to assisting state and local agencies with the cost of accreditation, the federal government could:

    ✓ create a special grant program for accreditation
    ✓ designate a percentage of categorical grants specifically for accreditation-related activities
    ✓ target health care reform funds to accreditation preparation activities
    ✓ make PHAB fees an allowable administrative cost under categorical grants

  o The federal government could offer incentives to accredited agencies in the funding application process for categorical grants by:

    ✓ adding scoring points to competitive grant applications based upon percentage of LHDs accredited in the state
    ✓ expediting applications from accredited agencies
    ✓ accepting accredited status as satisfying eligibility requirements

  o Create quality improvement staff positions in state and local health departments using Affordable Care Act funding.
- Make federal funding more flexible to support local plans and priorities determined through community health assessments and improvement plans (which are PHAB prerequisites).

- Avoid federal financial disincentives or penalties, use positive reinforcement.
**Discussion: Legal and Policy Lessons Learned**

This section presents the legal and policy lessons learned from the ten case study states with regard to developing state accreditation or related programs; preparing for the national accreditation program; and shared service delivery as an approach to accreditation.

**I. Developing State Accreditation or Related Programs**

- “There’s no way we could have moved forward...if the locals weren’t on board.” Creation of state accreditation and related programs and the adoption of related laws, regulations and/or policies involved extensive collaboration between state and local health practitioners. Interviewees stressed that the development of these programs required close collaboration among state and local health practitioners.

- “Building awareness [of elected officials] is a never ending process.” Some states developed extensive educational materials to educate legislators first on the role of public health and second on how accreditation would benefit citizens. Interviewees in these states felt intensive education was the key to winning the support of legislators and other stakeholders. Given the high degree of turnover among local and state elected officials, as well as among other stakeholders, education and awareness-raising must be viewed as an ongoing process.

- “Technical assistance was really about reducing the level of fear, making [LHDs] understand that we were with them...we were going to help them succeed in this.” In some states, extensive technical assistance programs were provided by the state health department (or a partner agency) to assist LHDs in developing the capacity and skills to meet accreditation/certification requirements (e.g., how to conduct a community health assessment and develop a corresponding community health improvement plan). Interviewees felt that these technical assistance programs helped reduce LHD fears around accreditation and related programs and the passage of related laws and regulations.

- “It’s not about how big you are, it’s how good you are.” In one state, accreditation was a way to shift the focus of legal/policy discussions away from consolidation (or “districting”) of small health departments. Improving the overall quality of a local health system is not about reducing the number of health departments, but about ensuring that all health departments, regardless of size, are providing a basic set of defined services.

- “We needed the effect of the law.” In states that opted to pass statutes to create their programs, interviewees reported that stakeholders want to formalize and/or institutionalize programs so they would have more weight and a far-reaching effect.
“We had pilot counties...to prove to our county commissioners and to our legislators that this could work...so when our law passed, we had those pilot standards so we didn’t have to reinvent the wheel.” In two states where laws establishing accreditation were recently passed, interviewees reported that piloting accreditation standards allowed for valuable lessons to be learned, and demonstrated proof of concept to legislators and other elected officials, thereby garnering support for passage of legislation. In addition, once laws were passed, rule-making related to standards was not an onerous process as pilot standards only needed to be modified to incorporate lessons learned.

II. Preparing for the National Voluntary Accreditation Program

“Lead by example.” Some state health departments have made the determination that to effectively encourage local participation in the national program, they must lead by example. Interviewees in these states indicated the state health department plans to be “first in line” to apply for accreditation when the national program is launched later this year.

“Don’t lose information.” In states that are considering modifying their laws, regulations, or policies to recognize accreditation by PHAB as meeting the requirements of state programs, interviewees indicated that any modifications would require that community health assessments and plans be submitted to the state for record-keeping, but not review, purposes. In this way, the state can continue to track necessary data and monitor the priorities that LHDs are setting for themselves.

III. Shared Service Delivery as an Approach to Accreditation

“It’s the region that enables the counties to do what they need to do, not the other way around.” Interviewees reported that the key to local support for shared service delivery is empowering locals to determine their own partners and arrangements. There are many models for shared service delivery that do not entail consolidation of health departments. “We’ve found what works best is when the locals group themselves according to their relationship and need...When it works best it is when it’s their idea rather than it is forced upon them.”

“If you are a home rule state, don’t pretend that a need to share services doesn’t exist. As we look at accreditation...it’s the elephant in the room.” Some interviewees in decentralized states expressed concern that state and local health departments were vulnerable to reorganization (e.g., merging of health departments or consolidation of health departments into umbrella human service organizations) that might reduce their autonomy and visibility. Shared service delivery (based in interlocal agreements and limited to specific services) was viewed as a way of maintaining, rather than losing, autonomy. “I think health department directors are...more open now than they’ve ever been, at least the leaders, the
ones on the cutting edge...are much more receptive to sharing of services as a potential solution for a range of problems.”

- “Have a meeting of the minds on the rules of the game.” Effective regional cooperation for shared service delivery involves carefully laying out ground rules and devising a governance structure. In many states, interlocal agreement acts require that participating agencies spell out, for example, the duration and purpose of the agreement, manner of financing and of establishing and maintaining a budget, and methods for terminating the agreement.
Additional Resources

Articles and Reports


Laws and Regulations
Citations for relevant laws and regulations for the mapping and case study states are included in Tables 1 and 2.

Websites


Public Health Accreditation Board. http://www.phaboard.org/
Conclusion

The key findings and legal lessons learned from the ten case studies presented in this report are intended to be of use to other states as they examine their existing state public health statutes, regulations, and policies in preparation for the national accreditation program. Motivating many states, in part, is the belief that accreditation might one day be tied to eligibility for federal and other funding. However, interviewees also stressed the value of the accreditation process itself – from developing critical assessment and planning skills among public health practitioners, to improving the efficiency, accountability, and sustainability of public health systems, to gaining recognition from elected officials which can translate into additional resources.

“Now they have a great community health assessment that really reflects their county...I think there [is] intrinsic value to the system to have some of these smaller health departments learning how to do this.”
- State public health official

“We’re working towards accreditation, but for me that is not the goal, it’s kind of a side benefit. The goal is to operate more efficiently.”
- Local public health administrator

“We’ve seen some agencies that got recognition [for being accredited] from their local government structure that meant more money for them, or better access to the mayor’s office.”
- Director of a nonprofit public health institute
Case Studies
ILLINOIS: Local Health Department Certification Program

Legal Framework: Title 77, Section 600 of Illinois Administrative Code (1993)

Following the release of the 1988 Institute of Medicine Report, *The Future of Public Health*, the Illinois Department of Public Health (IDPH) initiated an extensive and inclusive strategic planning process called *Project Health*. Through *Project Health*, IDPH, local health officials, and other stakeholders examined the Illinois public health system’s capacity for assessment, policy development, and assurance. A key finding was the need to increase assessment capacity at the state and local level. Certification of LHDs was initiated in 1993, with a key focus on community health assessment and planning.

Certification of LHDs in Illinois is based in statute (55 ILCS 5) and regulation (Title 77, Section 600 of Illinois Administrative Code). Certification is awarded for a 5-year period to LHDs that employ an executive officer and meet eight public health practice standards as defined in Title 77, Section 600. These standards focus on assessment, policy development, and assurance practices.

IDPH serves as the governing body for certification and provides LHDs with training, technical assistance, data, and resources needed to complete community health assessments. The Illinois Project for Local Assessment of Needs (IPLAN) provides a framework for meeting most assessment and policy development practice standards.

Interviewees explained the rationale behind basing certification in statute and regulation. While certification of LHDs is voluntary, stakeholders felt it needed to be tied to “something meaningful.” Therefore, IDPH outlined the certification process and made certification an eligibility requirement for Local Health Protection Grants awarded by IDPH.

To assist LHDs in meeting certification requirements when the program was first launched, IDPH developed a uniform dataset of local health information and established an intensive, funded technical assistance program. Technical assistance focused largely on how to conduct a community health assessment, develop a community health plan, and complete an organizational capacity assessment. Interviewees noted that the provision of extensive technical assistance at the project’s launch eased fear on behalf of LHDs regarding their ability/capacity to meet certification requirements around assessment and policy development.

To apply for renewal of certification, a LHD must submit an application along with the community health assessment and community health plan (IPLAN), evidence that the Board of Health has adopted the plan, and evidence that the LHD has conducted an organizational self-assessment or strategic plan. IDPH may also at its discretion conduct a site visit to review compliance with the other practice standards but no prospective evidence of this is required. The LHD must also demonstrate that it meets certain personnel requirements.
In 2005, the Illinois Accreditation Development Project (IADP) was funded by the Robert Wood Johnson Foundation through the Multi-State Learning Collaborative (MLC). IADP’s purpose is to “develop an improved performance measurement framework for local health departments and to use the results of performance measurement to improve the quality of public health practice.” In 2007, IADP developed and piloted a set of accreditation standards with seven LHDs as part of preparations for developing a new voluntary accreditation program in Illinois. Ultimately, IDPH determined that it would not develop its own state-based accreditation program, but would instead encourage LHDs to participate in the national voluntary accreditation program. IDPH has also determined that it will maintain its certification program. To that end, IDPH is currently considering a mechanism under the existing regulatory framework to recognize accreditation by PHAB as satisfying Illinois certification requirements.

Interviewees reported that “regionalization” is historically a sensitive topic in Illinois, and is not receiving significant attention in discussions regarding LHD participation in the national voluntary accreditation program. A divide between larger northern LHDs and smaller southern LHDs in Illinois exists, as evidenced by the splitting off of ten northern counties from the Illinois Association of Public Health Administrators (IAPHA) to form the Northern Illinois Public Health Consortium (NIPHC), established in 2002. These organizations represent different advocacy positions with regard to public health interests. For example, the NIPHC, in its strategic plan, promotes revising “distribution formulas used by IDPH for the allocation of grant and contract funds (e.g. bioterrorism, pandemic flu, etc.) to greater promote a regional approach to local public health and better take into account population, need and capacity factors.”

IOWA: Voluntary Accreditation Program


In 2004, the Iowa Department of Public Health (IDPH) launched an initiative focused on improving the overall public health system in the state. Two factors motivating the initiative were the establishment of public health standards in other states and the sense that public health service delivery across Iowa was inconsistent and fragmented. IDPH commissioned the Work Group for Redesigning Public Health in Iowa; members included both state and local public health practitioners. Between 2005 and 2006, regional meetings of state and local public health partners were held throughout the state and the Work Group subsequently developed standards for public health practice in an effort to define the services every Iowan could expect from public health. Over 150 state and local public health practitioners participated in the process. The standards apply to governmental public health system, which includes local boards of health, the state board of health, as well as a designated agency in every jurisdiction and the Iowa Department of Public Health.

Building on the public health standards (formalized in 2007), state and local public health practitioners moved forward with the legislative enactment of the Iowa Public Health Modernization Act in 2009. The Act establishes a voluntary accreditation system for local and state health departments to “enhance organizational capacity and assure a basic level of public health service delivery in each of Iowa’s counties.” The Act establishes IDPH as the lead agency administering accreditation and creates a Public Health Advisory Council to develop the accreditation process, as well as a Public Health Evaluation Committee to evaluate the effectiveness of the accreditation program. In addition, the Act establishes the Governmental Public Health Fund to assist local boards of health in meeting accreditation standards. Monies reallocated or deposited into the fund by IDPH are non-revertible, with at least 70% of funds available to local boards of health and up to 30% available to IDPH.

The accreditation process will be piloted beginning in August 2011 and administrative rules are currently being developed. The program is set to launch in 2012.

State and local health practitioners determined that a statute was necessary to ensure that public health practice standards and the new voluntary accreditation program had a long-reaching effect. As one interviewee commented, “We needed the effect of the law.” In addition, there was a desire on behalf of state and local health practitioners to “formalize” the standards and accreditation program in statute to give them more weight.

State and local public health practitioners worked together and also reached out to partner organizations (e.g., local environmental health, Iowa Association of Counties, Iowa Medical Society, Iowa Nurses Association, and the state public health laboratory, as well as three universities and key legislators) to educate them about the Public Health Modernization Act and build support for its passage. Educational materials were developed by IDPH (e.g., fact
sheets that provided tangible examples of how the Act would benefit Iowans by improving public health services) and used to educate legislators and other stakeholders on the Act in the months preceding the 2009 legislative session. Interviewees noted that this educational outreach was critical to the passage of the Act.

Interviewees reported that three additional factors aided in the passage of the Act. First, accreditation was voluntary (and therefore not an “unfunded mandate”). IDPH emphasized that accreditation was voluntary, that not all LHDs would want to do it immediately, but that it was important to provide the opportunity for LHDs that were interested given the national accreditation movement. A second aspect of the Act that appealed to legislators and other stakeholders was that the standards in the Act were “draft standards.” They would be piloted before the program was officially launched, allowing time for input from local communities as to what Iowans should expect from public. Third, the idea that some smaller, rural local health departments might end up sharing delivery of services in order to meet accreditation standards was seen by legislators as opportunity to improve efficiencies. At the same time, IDPH did not attempt to dictate how LHDs should share service delivery, but rather provided models of different ways service delivery could be shared to meet standards (for example, how LHDs could collaborate to share delivery of environmental health services).

Interviewees reported that while some LHDs are comfortable sharing service delivery (to meet accreditation standards) through contracts and memoranda of understanding, there are those that would like to join together more formally. As follow up to the Public Health Modernization Act, Iowa recently passed legislation that allows for counties to establish district boards of health. The Local Public Health Governance Act (2010) states that “county boards of any two or more geographically contiguous counties may at any time submit a request to from a district board to the state department...and shall include...a written narrative that explains how the formation of a district board will increase organizational capacity and capability to provide population-based and personal public health services compared with operating as individual county boards.”

IDPH plans to seek accreditation from PHAB at the state level, and hopes to work with PHAB to have the Iowa state program “deemed equivalent.” If this occurs, a LHD that is accredited by IDPH will be deemed equivalent to having met PHAB accreditation requirements.

Iowa’s Public Health Advisory Council is currently developing administrative rules related to Iowa’s accreditation program. As the PHAB implementation process moves forward, it is likely that these new regulations will eventually need to address equivalency in relation to the national accreditation program. For example, the rules may simply need to state that accreditation by PHAB is “deemed equivalent” to accreditation by IDPH.
KANSAS: Regional Cooperation and Quality Improvement

Legal Framework: Kansas Interlocal Cooperation Act (1957)

Following the influx of federal funds for public health preparedness in 2002, fifteen preparedness regions were created in Kansas. The Kansas Association of Local Health Departments (KALHD), Kansas Association of Counties (KAC), and Kansas Department of Health and the Environment (KDHE) worked collaboratively to incentivize what was then termed “bottom-up regionalization” (now called “regional cooperation”). A KALHD team was formed to negotiate the state/local split of federal preparedness funds; ultimately 50% of funds were allocated to the state and 50% to LHDs. KALHD then convened a meeting of its members to determine how to allocate their portion of funds among the state’s 100 LHDs. Members (i.e., LHDs) decided to use 15% of their share to incentivize the creation of regions in order to develop the infrastructure necessary to deliver emergency preparedness and response services. LHDs were able to choose their own partners and create agreements that allowed for certain functions to be provided by the region, while others were provided by LHDs individually. Smaller counties were given a greater per capita allocation in order to make them more attractive partners. A region was defined as being comprised of at least three contiguous counties. Nearly all LHDs voluntarily joined regions; currently, 98 of the state’s 100 LHDs belong to a preparedness region.

Interviewees reported that allowing LHDs to determine their own regions was critical to the successful development of the fifteen original preparedness regions. The approach allowed LHDs to “maximize local control while at the same time gaining economies of scale.” The creation of locally-defined preparedness regions also represented a “whole new level of local participation in the planning process.” KALHD, hoping that this might be a model for involvement of LHDs in future planning processes, helped build a system of performance management into contract (between LHDs and KDHE) to demonstrate LHD accountability and track local accomplishments.

Regional cooperation in Kansas is defined as “groups of local health departments in a region working together to deliver all necessary services while still retaining their autonomy and independent governance.” Regional cooperation is not consolidation of local health departments. Instead, groups of LHDs work together to identify common gaps in service provision and develop formal agreements around how they will cooperate to provide those services. Other services, effectively provided by LHDs individually, are not part of the agreement.

The basis for these agreements is Kansas’ Interlocal Cooperation Act. Adopted in 1957, the Act permits “local government units to make the most efficient use of their powers by enabling them to cooperate with other localities, persons, associations and corporations on a basis of mutual advantage and thereby to provide services and facilities in a manner and pursuant to
forms of governmental organization that will accord best with geographic, economic, population and other factors influencing the needs and development of local communities.”

The Act requires that interlocal agreements specify duration, purpose, manner of financing and of establishing and maintaining a budget, and methods for terminating the agreement. In addition, the agreement must specify the organization of any separate legal or administrative entity created by the agreement. If a separate legal entity is not created, the agreement must contain a provision for an administrator, a joint board, or one of the participating public agencies to be responsible for administering the cooperative undertaking, and must also specify the manner of acquiring, holding and disposing of real and personal property.

A model interlocal agreement for public health regional cooperation has been drafted by KALHD, KAC, and a legal consultant. It is available in the document “Proposal for the Implementation of a Multi-Jurisdictional Accreditation Process.” One issue related to regional cooperation that stakeholders are currently exploring is whether or not regions should create a separate legal entity to conduct the joint undertaking.

The national accreditation movement provided the impetus for Kansas to explore expanding regional cooperation beyond preparedness to include other public health services and address accreditation requirements. In order to prepare LHDs for accreditation, public health stakeholders in Kansas, such as KALHD and the Kansas Health Institute (KHI), felt they needed to promote a culture of standardization of procedures and adoption of best practices. To this end, Kansas has engaged in several related projects where Kansas’ system of “regional cooperation” has been piloted. These projects include Kansas’ participation in phases two and three of the Multi-State Learning Collaborative (MLC) focused on regional quality improvement, a National Association of County and City Health Officials (NACCHO) regionalization project, and a regional accreditation project funded by the Kansas Health Foundation. The latter project is exploring how multi-jurisdictional regions in Kansas might apply for accreditation through PHAB, and has proposed a regional accreditation application process to PHAB.

Moving forward with regional cooperation for delivery of other public health services has been facilitated by involving local elected officials (i.e., county commissioners) in the process and educating them on both regional cooperation and accreditation. Interviewees reported that a major success factor in creating regions has been careful execution of interlocal agreements to determine the governance structure and “rules of engagement” for regions upfront – for example, laying out how funds will be allocated, who will be responsible for what, how disputes will be resolved. As one interviewee commented, “Have a meeting of the minds on the rules of the game...then you can start working on strategic planning.”
MICHIGAN: Local Public Health Accreditation Program


In 1996, the Michigan Association for Local Public Health convened the Accreditation Steering Committee to develop the state’s accreditation program. Stakeholders on the Committee included representatives from LHDs, Michigan Association of Counties, Michigan Department of Agriculture (MDA), Michigan Department of Community Health (MDCH), Michigan Department of Environmental Quality (MDEQ), and the University of Michigan School of Public Health. “The goals of the program were to improve the quality of services provided by LHDs, to provide a set of standards by which all LHDS could be measured, to provide a coordinated approach to program reviews that were already underway…and to also provide accountability that resources were being used effectively,” explained one interviewee.

Four LHDs piloted the program in 1997-98, and the first accreditation cycle was launched in 1999. The accreditation process involves a self-assessment, on-site review, and corrective action plan. LHDs are reviewed for accreditation every three years. Currently, 44 of 45 LHDs in Michigan are accredited. MDCH provides funding and oversight for the program, working collaboratively with LHDs, the Michigan Public Health Institute, Michigan Association for Local Public Health, and the Michigan Departments of Agriculture and Environmental Quality.

The Michigan Local Public Health Accreditation program is based in statute and policy. Michigan’s Public Health Code of 1978 allows MDCH to establish minimum standards for the delivery of required and allowable services by LHDs. Per MDCH Policy 8000 (“Principles Governing Development and Adoption of the Minimum Program Requirements”), MDCH establishes and adopts “minimum standards of scope, quality, and administration for the delivery of required and allowable services as set forth under the Public Health Code” though a process that involves input from LHDs and other stakeholders. Minimum Program Requirements (MPRs) are defined as “objective criteria for meeting requirements of law, rules, department policy, or professionally accepted methods of practices for the purposes of ensuring quality, availability and effectiveness of services and activities.” Through an annual process, proposed changes to MPRs are reviewed by a Standards Review Committee comprised of local and state public health stakeholders.

MDCH assures that MPRs are met through the state’s accreditation program. The accreditation program is required in annual Comprehensive Planning, Budgeting, and Contract (CPBC) agreements between MDCH and each LHD. Part II, General Provisions, Section P(1) of the Agreement states “All Contractors shall comply with the local public health accreditation standards and follow the accreditation process and schedule established by the Department to achieve full accreditation status.”
In preparation for the national voluntary program, Michigan has participated in the Multi-State Learning Collaborative. A component of the Michigan project focused on the development of a voluntary continuous quality improvement supplement to its accreditation program that would, in part, help LHDs prepare for the national program. At the state level, MDCH served as a beta test site for PHAB.

Currently, MDCH is not considering “deeming” a LHD that is accredited by PHAB as meeting state accreditation requirements. Interviewees reported that the MPRs that are part of the state’s accreditation program are negotiated jointly between state and local public health workgroups, and are grounded in state law, rules, and policy, as well as federal laws and requirements of funders. Thus, MPRs are “vastly different” from PHAB standards. Interviewees further reported that before Michigan could begin considering equivalency, more information was needed from PHAB.

Interviewees reported that Michigan’s legal framework for accreditation has served the state well, and no modifications are currently being considered in light of the national program. By embedding accreditation standards (i.e., MPRs) in annual CPBC Agreements, accreditation is mandatory. In addition, MPRs are negotiated by state and local public health workgroups through an open, transparent process. Thus, even if some stakeholders do not fully support all standards, they at least have had an opportunity to have their comments heard. Because MPRs are negotiated annually, Michigan has experienced “a tremendous amount of flexibility and operational elasticity as to how to accomplish accreditation.”

Michigan’s 45 LHDs are a mix of single-county (30), multi-county district (14), and city (1) LHDs. As previously stated, 44 of 45 are currently accredited by MDCH, MDA, and MDEQ. There are no immediate plans for further shared service delivery among LHDs to meet state or national accreditation standards.
MISSOURI: Voluntary Local Public Health Agency Accreditation Program

Legal Framework: Independent of State Law, Regulation, or Policy

In 1999, the Missouri Department of Health and Human Services (MDHHS) received a Turning Point grant from the Robert Wood Johnson Foundation. Turning Point was a nationwide initiative focused on strengthening public health systems within the United States. Missouri’s Voluntary Accreditation Program for Local Public Health Agencies grew out of Missouri’s Turning Point partnership. In 2002, the Missouri Institute for Community Health (MICH) was established as the program’s accrediting body. MICH is an independent, nonprofit organization. MICH seeks to “convene and facilitate conversations about the future of the public’s health in a community-based health system, provide standards of practice for local public health agencies, address workforce issues, and identify learning opportunities to support community health activities now and into the future.”

Accreditation in Missouri is voluntary. The accreditation process involves four steps: an application, self-assessment, MICH review, and MICH’s accreditation decision. Accreditation is for a three-year period; LHDs can apply for primary, advanced, or comprehensive accreditation. Combined application and accreditation fees range from $1950 - $4400 depending on the level of accreditation. To date, 17 of Missouri’s 114 LHDs have been accredited; these 17 LHDs serve approximately 33% of the state’s population.

Interviewees reported that, as the development of the accreditation program progressed, it became apparent that “state accrediting local public health would not be appropriate” in Missouri. State and local public health stakeholders determined that it would be more suitable, in a decentralized state like Missouri where LHDs are autonomous and have local funding, for an independent group to serve as the accrediting body. MICH was subsequently established and is governed by a Board of Directors comprised of representatives from businesses, academia, MDHSS, LHDs, and professional associations.

Two health departments – Dallas and Hickory Counties – applied for and received “dual primary accreditation” from MICH. Shared service delivery is not uncommon in Missouri, and arrangements occur among LHDs for particular services, such as environmental health. “We’ve found what works best is when the locals group themselves according to their relationship and need...When it works best it is when it’s their idea rather than it is forced upon them,” reported one interviewee. In most cases where service delivery is shared, LHDs work through locally negotiated contract and memoranda of understanding.

MDHSS and some LHDs plan to apply for accreditation through PHAB. Stakeholders are grappling with the question, “If you have a voluntary [state-based] accreditation program, are you going to continue that program with the national program already in existence?”
**MONTANA: Pilot Project for Implementing National Public Health Standards**


In 2008, the administrators of two frontier LHDs (i.e., serving a population under 5,000), both public health nurses, partnered to address the challenges faced by local public health in Montana. The two embarked on a grassroots initiative that culminated in the passage of House Bill (HB 173), which created a pilot project aimed at building a sustainable model for local public health in Montana using, in large part, the standards, resources, and tools developed by PHAB for its national accreditation program. HB 173 built on the Montana Public Health Modernization Act of 2007. The 2007 legislation put a localized version of the 10 Essential Public Health Services into law, thereby laying the foundation for the standardization of public health practice across the state.

To gauge the extent of the challenges faced by local public health in Montana, the nurses conducted extensive primary and secondary research (primary data was gathered through phone surveys of Montana’s frontier, rural/small, and medium counties; secondary data collected included county health indicators, poverty rates, etc.). Their research revealed that there was little standardization of public health services throughout the state, and more importantly, the infrastructure to support standardization of practice did not exist. They concluded that a legislative solution was needed to create a sustainable model for local public health in Montana.

With data in hand, the nurses set out to educate stakeholders on the status of local public health in Montana. They also sought to educate stakeholders on the need to establish a statewide definition of a functional LHD in order to effectively provide services and improve the health of citizens. Two key public health groups joined the effort - the Association of Montana Public Health Officials (AMPHO) and the Montana Public Health Association (MPHA). The nurses reached out to their local state representatives, one a Democrat, the other a Republican.

To aid in educating stakeholders, informational materials, such as bookmarks containing the 10 Essential Public Health Services, fact sheets, and talking points were developed. Through information-sharing meetings, attendance at conferences, letters to elected offices, and continuous direct contact (i.e., phone, email) with stakeholders, the nurses and their partners spread their message and gathered support. With bipartisan support from the two state legislators, HB 173 was introduced in the 2009 legislative session and enacted into law. Montana HB 173 established “a pilot project to help local public health agencies undertake activities related to meeting national guidelines.” HB 173 authorized MDPHHS to administer up to eight county pilot projects focused on “preparing for national accreditation by using nationally recognized public health standards and guidelines that are based in the 10 essential public health services as outlined by the national association of county and city health officials, the centers for disease control and prevention, the public health accreditation board, and other..."
national public health organizations." Oversight for the pilot project would be provided by the Montana Public Health Systems Improvement Task Force.

The bill required that pilot LHDs participate in a self-assessment and an evaluation of the pilot project, and complete measurement criteria established by MDPHHS. MDPHHS would serve as a resource for pilot LHDs, providing access to technical assistance and training.

So that lessons learned would apply to all sizes of LHDs, HB 173 required that grant awards be made to: a) two LHDs in counties with populations of 40,000 or more (large), b) one LHD in a county with a population between 20,000 – 40,000 (medium), c) two LHDs in counties with populations between 5,000 – 20,000 (rural/small), and d) three LHDs in counties with populations under 5,000 (frontier). One tribal LHD was to be included among the eight pilots. The bill allocated each pilot LHD $50,000 to carry out the project over a two-year period (i.e., $25,000 per year).

The pilot project is currently in its second year. Key outcomes of the pilot are to include an estimate of the cost of becoming accredited through the national program, an assessment of the ability of LHDs to become accredited, and “a roadmap, tools, and guidance for any and all local Montana public health agencies that wish to pursue accreditation.”

Interviewees reported that the successful passage of the bill was due to several factors. Having bipartisan support was important. Obtaining this support required the nurses and their partner organizations to devote substantial time and energy to educating their representatives and other stakeholders. Educating representatives and stakeholders required effective communication and a compelling story: local public health was facing tremendous challenges, but a sustainable model for public health could be created that would benefit the health of all Montanans.

At the time of this writing, all LHDs in the project have completed their “readiness reviews” using PHAB resources and tools to assess their capacity and performance. They are now working on completing accreditation prerequisites which include a community health assessment, community health improvement plan, and an agency strategic plan. Interviewees reported that even if not all LHDs in Montana become accredited, there is an “intrinsic value to the system” in learning how to conduct community health assessments and development improvement plans. “We’re working towards accreditation, but for me that is not the goal…it’s kind of a side benefit. The goal is to operate more efficiently.”

In an effort to continue the current pilots and add more LHDs to the project, HB 473 was introduced in the 2011 legislative session by one of the sponsors of HB 173. The bill has been tabled. Interviewees reported that the current economic climate is not conducive to continuing the project (in 2009, a state budget surplus and an influx of federal stimulus funds helped secure the $200,000 allocation for the pilot projects).
In their HB 173 Legislative Report, MDPHHS recommends encouraging “local public health agencies to work collaboratively and regionally on accreditation activities.” Specifically, the report includes a suggestion from small counties to create “cooperative regions to provide public health services utilizing the strength of each county in the region.” However, one interviewee clarified that regional cooperation is “in a state flux,” reporting that his/her LHD would likely go through accreditation as a single LHD and then “identify what the next steps might be to either assist our neighboring counties or develop some sort of regional structure. And that shouldn’t ever be a formal regional structure.”

MDPHHS plans to apply for state accreditation, and interviewees reported that at least 2 LHDs will be ready to apply for accreditation when PHAB is launched later this year. Additional LHDs are expected to apply in the future.
NEW HAMPSHIRE: Public Health Improvement Action Plan (2008)

Legal Framework: House Bill 491 (2007; establishes Public Health Improvement Services Council)

The New Hampshire Division of Public Health Services (DPHS) began conducting a comprehensive assessment of the state’s public health system in 2005. Together with 100 public and private health and human services stakeholders, DPHS used the National Public Health Performance Standards Program’s State Public Health System Assessment to rate New Hampshire’s ability to provide the 10 Essential Public Health Services. In 2006, the Public Health Improvement Action Plan Advisory Committee was established to guide the process of improving New Hampshire’s public health system.

In an effort to institutionalize the public health planning process, the Public Health Improvement Services Council was established legislatively in 2007, replacing the Advisory Committee. House Bill (HB) 491 states, “In order to sustain a public health planning improvement process to assure quality health services in New Hampshire, it is necessary to institutionalize that process through the development of the public health improvement services council and a required performance improvement planning process.”

The Council membership consists of one member of the house of representatives and one member of the senate; the commissioners of the departments of health and human services, education, and environmental services (or their designees); the director of the division of public health services; representatives from the Nashua and Manchester health departments; representatives of the New Hampshire Public Health Network, New Hampshire Public Health Association, Endowment for Health, Community Health Institute, New Hampshire Local Government Center, New Hampshire Hospital Association; representative of a community health center; and, a health insurer, licensed physician, and nurse.

The Council is charged with developing a public health improvement plan based on the 10 Essential Public Health Services (which are included in HB 491), making recommendations for the priorities and strategies to improve the state’s public health system, and monitoring the implementation of existing public health improvement plans. While the term of the Council has sunsettled, it continues to function under the auspices of the state Joint Legislative Oversight Committee on Health and Human Services.

Interviewees reported that this statutory approach was taken in 2007 to provide more visibility for public health and institutionalize the performance improvement planning process. “You write a plan, it sits on a shelf, that’s the end of it...we really wanted this to be institutionalized.”

In 2008, New Hampshire’s Public Improvement Action Plan was released. The plan presented the results of the statewide assessment and outlined six strategic priorities for improving public health. These included: 1) inform, educate, and empower people about health issues, 2)
monitor health status to identify and solve community health problems, 3) mobilize community partnerships and actions to identify and solve health problems, 4) develop policies and plans that support individual and community health efforts, 5) develop a communication plan to convey importance and value of public health, and 6) develop a plan to assure a competent public health workforce. Action steps were developed for each priority area. In 2011, DPHS released a progress report detailing the accomplishments achieved in reaching each priority.

In a related effort, New Hampshire has been working to create a regional public health infrastructure since 1997. While each of New Hampshire’s 234 towns has a health officer (often a volunteer), only two comprehensive LHDs exist in the towns of Manchester and Nashua. In 1997, through the Turning Point initiative, over 250 health and human services practitioners participated in a strategic planning process that identified a pressing need to strengthen local public health capacity. With additional Turning Point funding, the state began creating community coalitions to organize the delivery of the 10 Essential Public Health Services, which are largely provided by nonprofit organizations, such as community health centers, social service agencies, and others. Four community coalitions, covering 37 towns, were originally created in 2001; with the influx of federal preparedness funds in 2003, additional coalitions were created. These coalitions are now referred to as Public Health Networks. Currently, New Hampshire has 15 regional public health networks (PHNs) that cover all towns in state.

The New Hampshire Public Health Network (NHPHN) “works to assure coordinated and comprehensive delivery of essential public health services and serves as a local liaison with state agencies involved in the public's health and safety. The Network is comprised of community-based partnerships involving broad public health interests including local health departments and health officers, fire, police, emergency medical services, health care providers, social service agencies, schools, media and advocacy groups, and leaders in business, politics and faith working together to address complex public health issues.” Each PHN has a lead agency. Lead agencies include hospitals, municipalities and counties, private nonprofit organizations, nonprofit community coalitions, and LHDs.

In developing a regional public health infrastructure, interviewees noted the importance of building a system that might ultimately be accreditable. A legal issue that has arisen in this regard is how regional structures will address governance issues. DPHS has established a Public Health Regionalization Task Force; one of the Task Force’s goals is to determine how regional PHNs can be linked to local or regional government. While a long-standing New Hampshire law allows towns to voluntarily joint together to form health districts, none have chosen to do so. Interviewees reported that municipalities may not have taken advantage of this statute because of the authority given to the district board to create a budget and “draw upon the treasurer of each town or city within the district for such funds as may have been apportioned to each to pay the costs of operating the district. Such apportionment shall be based upon the population of the towns and cities in the district.”
The Task Force is currently working with regions on completing a governance assessment to determine each region’s readiness to serve in a governance function and to examine the potential types of lead public health entities. The Task Force has stated that it recognizes state laws will likely need to be changed to create “public health councils” to provide regional oversight without usurping local authority.

DPHS is currently working on completing the prerequisites for national accreditation. An agency strategic plan was been completed in 2010 and updated in 2011. A state health assessment, the New Hampshire State Health Profile, was published in 2011. State partners are working on a state health plan. The state’s two LHDs (based in Manchester and Nashua) are also working on accreditation prerequisites.
NORTH CAROLINA: Local Health Department Accreditation Program

Legal Framework: Senate Bill 804 (2005) and North Carolina Administrative Code, Title 10A, Chapter 48

In 2002, the North Carolina Association of Local Health Directors (NCALHD) created a committee to explore the development of an accreditation system for LHDs. The NCALHD Accreditation Committee included representatives from NCALHD, the North Carolina Division of Public Health (NCDPH) of the Department of the Health and Human Service (DHHS), and the North Carolina Institute for Public Health (NCIPH) at the University of North Carolina (UNC) Gillings School of Public Health. The NCALHD Accreditation Committee presented its final report and recommendations for an accreditation system in 2003.

In a parallel effort in 2002, State Senator Fletcher Hartsell, Linda Attarian (attorney to the North Carolina Speaker of the House), and a former local health director, John Shaw, participated in UNC’s National Public Health Leadership Institute. For their project, the three drafted Senate Bill 672: A Bill to Strengthen the Infrastructure in North Carolina. SB 672 was introduced in 2003 but failed to pass both houses.

In 2004, inspired by the work of Hartsell, Attarian, and Shaw, DHHS Secretary Carmen Hooker Odom created the Public Health Task Force (PHTF) to strengthen the state’s public health system. The Task Force was comprised of DHHS and other government representatives, local health directors, county commissioners, state senators and representatives, and members of professional associations and nonprofits. One of the Task Force’s six committees focused on accreditation of LHDs. In the Task Force’s final report for 2004, the PHTF Accreditation Committee recommended establishing a mandatory accreditation program for LHDs. They also recommended that “Local health departments seeking accreditation shall explore options for meeting the standards including inter-local agreements, partnerships and districting as changes needed to meet the standards, but all such decisions shall be entirely at the discretion of the local agencies involved.”

In 2004, accreditation standards were piloted in six LHDs. The following year, the standards were modified and again piloted, this time in four LHDs. Different sized health departments (large, medium, small) were selected as pilots from among those that volunteered. The directors of the six LHDs that participated in the 2004 pilots found the process extremely valuable. They agreed to make a video that was used to demonstrate the value of the accreditation process to county commissioners, local board of health members, and other stakeholders. In the second accreditation pilot phase (2005) two LHDs were chosen that had a shared service delivery arrangement (one LHD provided maternity care in the other LHD’s county). Both LHDs were able to meet accreditation standards.

In 2005, Senate Bill (SB) 804 was enacted, establishing a mandatory accreditation program for LHDs. SB 804 established a 17-member independent Accreditation Board within NCIPH, to be
comprised of four county commissioners, four members of local boards or health, three local health directors, two NCDPH representatives, one representative from the Division of Environmental Health, and three at large members. Members are appointed by North Carolina’s Department of Health and Human Services Secretary. The Board is charged with assigning an accreditation status to each of the state’s 85 LHDs. An Accreditation Administrator, within NCIPH, serves by legislative mandate.

SB 804 charged the Commission for Public Health with adopting rules establishing accreditation standards for LHDs. Title 10A, Chapter 48 of North Carolina’s Administrative Code includes implementing regulations related to accreditation. The accreditation process is established, which includes a self-assessment and site visit. Forty-one benchmarks (and 148 related activities) are outlined; a LHD must meet 31 benchmarks to achieve accreditation status. All LHDs are required to have applied for initial accreditation by December 1, 2014.

Each year, 10 LHDs are selected to undergo the accreditation process and, for the first four years, were provided $25,000 to offset preparation costs. Program funding is determined annually in the state’s Appropriations Act. In 2009-2010, the program was suspended for a year due to a state budget crisis. In 2010-2011, the funding for the program was restored at approximately 50% of previous levels. However, no LHDs were awarded funds to offset preparation costs in either 2009-2010 or 2010-2011. To date, 55 LHDs have been accredited.

The state health department, to demonstrate to LHDs and other stakeholders its willingness to go through the accreditation process, participated in an accreditation “state pilot” in collaboration with the Division of Environmental Health (DEH). A committee of local health directors created standards for the state health department and NCDPH and DEH pulled together the necessary documentation. NCIPH was contracted to conduct a state site visit, using the same methods used to evaluate LHDs, but using national accreditation experts and one local health director as site visitors. While there was no accrediting body to award accreditation, NCIPH provided feedback on strengths and weaknesses.

Interviewees reported that the policy discussions around strengthening the local public health infrastructure in the early 2000’s included concerns that there were too many LHDs and that some were too small to function effectively. Some stakeholders were of the opinion that the local public health infrastructure could be improved by reducing the number of health departments. A proposal was made by a legislator to limit the number of LHDs in the state to 20 – 25. In essence, this meant creating district LHDs. Other stakeholders argued that limiting the number of LHDs in the state, or requiring that a certain minimum population had to be served by an LHD, involved the setting of arbitrary standards that would not necessarily improve quality. The discussion was reshaped to move away from the size and number of LHDs in the state, to address LHDs’ capacity to deliver essential services. “It’s not about how big you are, it’s how good you are.” This message resonated with stakeholders, and consensus was reached to move the discussion away from “districting” to focus on accreditation.
Interviewees reported that the 2004 and 2005 pilots served to facilitate rule-making following the passage of SB 804. As one interviewee commented, “I can’t think of any examples where we had an ability to pilot a rule before we adopted it. So this was pretty unique and it made rule-making very easy.”

Interviewees reported that having a mandatory accreditation program based in statute has resulted in significant progress in a short period of time (55 out of 85 LHDs accredited in just five years). A downside, however, is a lack of flexibility. “Now the only flexibility we have is with our guidance documents...it’s not as flexible in terms of incorporating feedback as a system that didn’t have statutory and administrative code language around it.”

With regard to the national voluntary accreditation program, North Carolina hopes to have the state program “deemed equivalent” to accreditation by PHAB. If this occurs, a LHD that is accredited by the North Carolina Accreditation Board would be deemed equivalent to having met PHAB accreditation requirements.

In recent developments, the Governor of North Carolina, in her recommended budget for 2011-2013 (released February 17, 2011), has proposed eliminating funds for the state’s accreditation program, declaring that “State efforts duplicate national programs that are available for local health departments to pursue accreditation.” While some case study interviews took place in the days immediately following the release of the Governor’s recommended budget, it was too early for interviewees to address, with any degree of certainty, what actions might be taken should funding be eliminated for a statutorily-mandated program (in addition, the state budget is not scheduled to be finalized until the summer of 2011). However, interviewees expressed concern about a potential situation where part of the population of the state is covered by an accredited LHD, and part is not. “I don’t know how, as a legislator, you can say we funded this program for [55] counties to get accredited, but for those of you who live in the areas served by the other health departments, we really don’t care whether your health department meets any minimum standards or not. I am hoping we can find some messages like that that will resonate with them - that they owe it to the citizens to make sure every health department at least one time, even if we aren’t allowed to do reaccreditation, but at least one time has to meet this set of standards that we say are critical for being able to deliver the 10 essential services.”
OKLAHOMA: Step UP Performance Management System

Legal Framework: State Health Department Policy

Public health in Oklahoma has a unique organizational structure. While the state’s 68 county health departments (CHDs) are part of the Oklahoma State Department of Health (OSDH) system, they have local county boards of health, receive a portion of their funding from local county taxes, and have strong relationships with community partners. While OSDH does not consider its system “regionalized,” there are 17 county health department administrators that are responsible for the state’s 68 CHDs. These 17 groupings of CHDs are called “administrative districts.” Seven counties do not have CHDs, and minimal services are provided by neighboring CHDs. In addition, there are two independent City-County LHDs that serve Tulsa and Oklahoma City respectively.

In 2006, OSDH began discussions with service areas and CHDs to develop a uniform system that would measure the performance of the state’s public health system. That same year, OSDH created the Office of Performance Management. The system that ultimately evolved is called the Step UP Performance Management System (Step UP stands for Strategies Toward Excellent Performance: Unlimited Potential). Step Up is a web-based system that provides OSDH, service areas, and CHDs with a defined system to “promote thoughtful planning and decision making toward programmatic and organizational goals and objectives, enhance the development of innovative activities and strategies for meeting those objectives, and assure periodic measurement of quantifiable performance measures important to achieving the selected goals and objectives.”

Through Step UP, OSDH is able to measure performance on key indicators.

In addition to monitoring progress towards goals and indicators, OSDH is working to align Step UP with PHAB standards. Through Step UP’s two main templates for CHDs, (County Health Department Overview and Public Health System Alignment template and Strategic Plan and Performance Measure template), users upload or create documents that align with the three PHAB’s prerequisites – a county health assessment, county community health improvement plan, and a strategic plan. A third template (Annual Review template) is used to measure progress on goals and objectives throughout the year by reporting progress on performance measures. A corresponding set of templates exists for the state health department.

Step-UP has received national recognition. In 2010, the system received a Digital Government Achievement Award from the Center for Digital Government, which recognizes outstanding agency and department websites and projects at the application and infrastructure level.

In preparation for PHAB, OSDH served as a state beta test site. Oklahoma has also been engaged in quality improvement efforts through participation in the Multi-State Learning Collaborative in partnership with CHDs, the Oklahoma University Health Sciences Center, Oklahoma Turning Point Council and local Turning Point partnerships, and the Public Health
Institute of Oklahoma. OSDH and the two independent city-county health departments plan to apply for national accreditation, with CHDs to follow.

Oklahoma has been successful in applying a policy approach to accreditation preparations. Interviewees reported that OSDH benefited from having the full support of the state’s public health leadership, including the Board of Health and Commissioner and Secretary of Health and Human Services, in moving forward with accreditation and quality improvement efforts.
WISCONSIN: Local Health Department Review Process


Wisconsin’s LHD Review Process was launched in 1998 following the development of administrative rules. Wisconsin Administrative Code - Chapter DHS 140: Required Services of Local Health Departments lists required services for three levels of LHDs (Level I, II, and III, with Level I being the most basic). DHS 140 also authorizes the Wisconsin Department of Health Services (WDHS) to direct a process to formally review all LHDs at least every five years. The regulations in DHS 140 were promulgated under the 1993 statutory authority of Wisc. Stats. 251.20 which directs WDHS to specify the required services for each of Levels I, II, and III LHDs. Reviews are led by WDPH’s regional offices using an assessment tool. To operate, a LHD must achieve a minimum of Level I status.

The Review Process evolved from a 1991 Wisconsin Division of Public Health (WDPH) quality improvement initiative. Wisconsin’s 92 LHDs have been reviewed twice since initial reviews were completed in 1998; currently, 11 LHDs have Level 1 status, 52 have Level II status, and 29 have Level III status.

Interviewees report that WDHS has been in the process of revising DHS 140 in order to reflect current or desired practices and requirements since 2002. The revision is being led by an Advisory Committee that includes 13 local health officers, the Wisconsin Counties Association, Alliance of Cities, and WDHS staff. Updates to DHS 140 currently under consideration include making DHS 140 consistent with efforts to apply for national accreditation by incorporating, for example, the administrative and infrastructure requirements and other standards that are necessary for PHAB accreditation. These efforts are consistent with the goals of the state health plan, “Healthiest Wisconsin 2020: Everyone Living Better, Longer” which calls for all Wisconsin health departments (state and local) to be accredited by 2020 using an established standard.

WDPH is also examining how to assure that there are not two parallel, disconnected LHD processes with the DHS 140 Review Process and the national accreditation program. Currently, this involves looking at commonalities between the requirements. WDPH is considering recognizing an LHD that is accredited by PHAB as having met the requirements of a certain level LHD, noting that LHDs do not want to go through two processes (i.e., the Wisconsin Review Process and the national accreditation program). While stakeholders have not yet determined what level national accreditation is equivalent to, interviewees noted that it will likely be Level II or III. Since LHDs must achieve a minimum of Level I to operate (and Level I is not as rigorous as accreditation by PHAB), WDPH will continue to administer the Review Process after the national accreditation program is launched.
Interviewees stated that, while specific changes to DHS 140 have been proposed, a final draft has not been agreed to by stakeholders, and revisions are still a work-in-progress. Immediate next steps include continued drafting with the involvement of state public health legal counsel, followed by reviews by WDPH, the Advisory Committee, Wisconsin Legislature, and legal counsel.

In a related but separate effort, the Wisconsin Joint Legislative Council’s Special Committee on Health Care Access is considering a revision to Wisc. Stats. 251.05(3) that would require LHDs to be consistent with the standards of PHAB relating to community health improvement processes and plans.52 These recommendations were made to the Committee by the Wisconsin Public Health Association (WPHA) and the Wisconsin Association of Local Health Departments and Boards (WALHDAB), independent of WDPH. No action has been taken by the Legislature.

In 2009, WDPH contracted with the Institute for Wisconsin’s Health, Incorporated (IWHI) to explore the status of shared service delivery among LHDs.53 IWHI reported that all 92 LHDs participate in collaborative efforts, although to widely varying degrees. Interviewees reported that conversations related to tying LHDs’ approach to accreditation with the potential need to share service delivery are in their “infancy.” However, one interviewee noted that, “Many health departments are saying, I need to figure out a way to meet these [accreditation] standards, and that’s an incentive for me to talk to my neighbors about it.”
Table 2. Results of Mapping Study

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<thead>
<tr>
<th>State*</th>
<th>Current Program/Activity</th>
<th>Legal Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>States with Accreditation Programs</strong></td>
<td></td>
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</tr>
<tr>
<td>Iowa</td>
<td>Iowa Voluntary Accreditation Program</td>
<td>Accreditation is by statute (Ch. 135A: Public Health Modernization Act of 2009)</td>
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<tr>
<td>Michigan</td>
<td>Michigan Local Public Health Accreditation Program</td>
<td>Accreditation is based in statute: MCL 333.2472(3) (Act 368 of 1978, Public Health Code) and state health department policy (Policy 8000)</td>
</tr>
<tr>
<td>Missouri</td>
<td>Missouri Voluntary Local Public Health Agency Accreditation Program</td>
<td>The accreditation program operates independent of state laws, regulations, and policies</td>
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<tr>
<td>North Carolina</td>
<td>North Carolina Local Health Department Accreditation Program</td>
<td>Accreditation is by statute (NCGS 130A-34.1) (2005); rules were developed in 2006 (10A NCAC 48A)</td>
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<tr>
<td><strong>States with Certification/Assessment Programs</strong></td>
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<tr>
<td>Illinois</td>
<td>Illinois Local Health Department Certification Program</td>
<td>Certification is by statute (55 ILCS 5) and regulation (Illinois Administrative Code Title 77, Section 600)</td>
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<tr>
<td>New Jersey</td>
<td>Compliance with New Jersey Public Health Practice Standards of Performance for Local Boards of Health in New Jersey</td>
<td>Compliance with practice standards is based in statute (NJSA 26:1A-15) and regulation (NJAC 8:52)</td>
</tr>
<tr>
<td>Ohio</td>
<td>Local Health District Improvement Standards</td>
<td>Standards are by statute (Ohio Revised Code 3701.342) and regulation (Ohio Administrative Code Chapter 3701-36)</td>
</tr>
<tr>
<td>Washington</td>
<td>State and Local Health Jurisdiction (LHI) Standards Review</td>
<td>Standards for Public Health in Washington State are required by statute (RCW 43.70.520) (1993)</td>
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<tr>
<td>Wisconsin</td>
<td>Wisconsin Local Health Department Review Process</td>
<td>The Review Process is based in statute (Chapter 251.20) (1993) and regulations (Chapter DHS 140) (1998)</td>
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<tr>
<td><strong>States with Performance Management/Quality Improvement Programs</strong></td>
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<tr>
<td>Indiana</td>
<td>Indiana State Health Department Essential Service Continuous Quality Improvement Training Program</td>
<td>Quality Improvement is by state health department policy</td>
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<tr>
<td>Kansas</td>
<td>Regional cooperation and quality improvement efforts are currently underway in Kansas</td>
<td>Quality improvement is by state health department policy</td>
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<td>State</td>
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<tr>
<td>Kentucky</td>
<td>The Quality Improvement Section of the Kentucky Department for Public Health strengthens and improves the quality of the practice of public health through a variety of methods</td>
<td>Quality improvement is by state health department policy</td>
</tr>
<tr>
<td>Montana</td>
<td>Pilot Project for Implementing National Public Health Standards</td>
<td>The pilot project is by statute (HB 173) (2009)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>The Office of Community Health and Performance Management of the Nebraska Division of Public Health strengthens the public health system through a variety of activities</td>
<td>Performance management is by state health department policy</td>
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<tr>
<td>New Hampshire</td>
<td>New Hampshire Public Health Improvement Action Plan</td>
<td>The plan was developed by the Public Health Improvement Services Council; the Council is a legislatively enacted body (HB 491) (2007)</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Step UP Performance Management System</td>
<td>Performance management is by state health department policy</td>
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<tr>
<td>South Carolina</td>
<td>Performance Management</td>
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*A total of 23 states were contacted. At the time of the study, four states indicated that they had no formal accreditation, certification/assessment, performance management, or quality improvement programs. These states are not included in the table.
Endnotes

5. Ibid.
17. Ibid.
21. Ibid.
28. Ibid.
29. No tribal LHDs applied and thus only 7 grants were awarded.
31. Ibid.
32. Ibid.
37. Ibid.
41. Ibid.
42. Ibid.