TELLING THE STORY OF PUBLIC HEALTH ACCREDITATION IN OHIO

EXECUTIVE SUMMARY

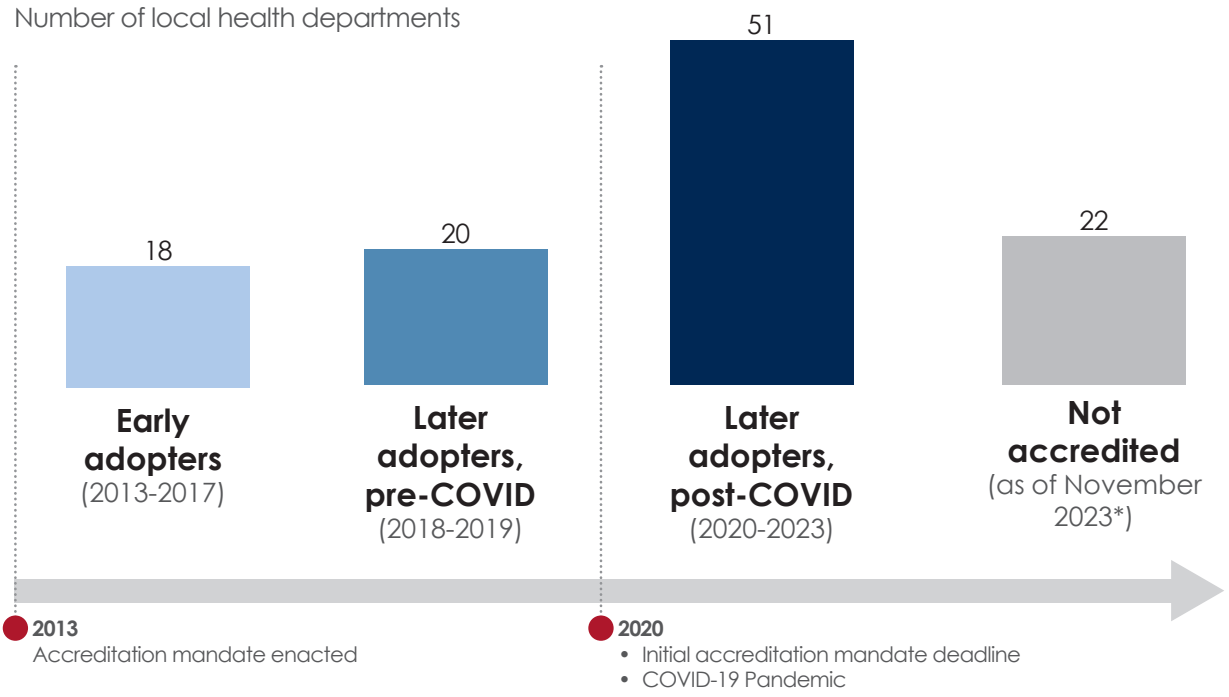
About this study

Ohio has a higher percentage of local health departments (LHDs) that have achieved Public Health Accreditation Board (PHAB) accreditation than any other state[1] and is the only state that requires LHDs to be accredited. PHAB commissioned this study to gain a better understanding of how accreditation has been implemented in Ohio and what Ohio's experience can teach PHAB and other states about how to maximize the positive impact of public health accreditation.

This study used a mixed-methods approach, combining qualitative and quantitative analysis of the following data sources:

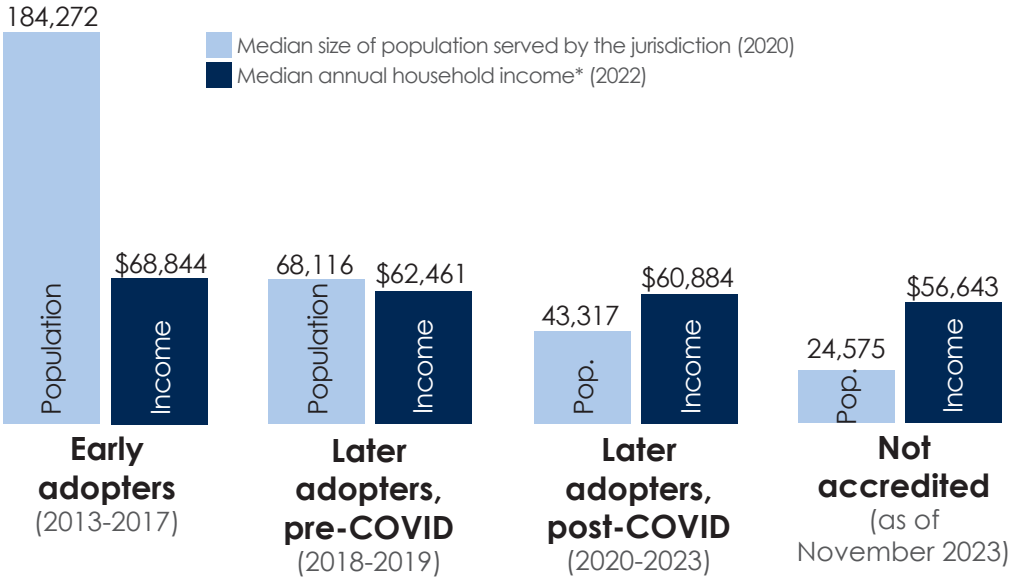
- **Focus groups:** Five groups with state and local public health leaders, including representatives from accredited and non-accredited LHDs (41 participants)
- **Key-informant interviews:** Interviews with public health leaders regarding the 21st Century public health grant (2 participants)
- **Social return on investment (SROI) discussion group:** One meeting with LHD and Ohio Department of Health (ODH) representatives to develop an outcome map for future analysis of the costs and benefits of accreditation (8 participants)
- **Annual Financial Report (AFR):** Data on agency-level staffing and spending, as well as attainment of the Foundational Public Health Services (FPHS) submitted by Ohio LHDs to ODH (state fiscal year [SFY] 2020 and 2021)
- **National Association of City and County Health Officials (NACCHO) Profile:** 2019 profile data for Ohio LHDs
- **NORC accreditation surveys:** Results from Ohio LHDs on accreditation surveys conducted by NORC for PHAB (2013-2022). (NORC is a research organization at the University of Chicago.)
- **Other secondary quantitative data:** PHAB data on the date of accreditation and reaccreditation for state and local health departments, Association of Ohio Health Commissioners (AOHC) data on population size of Ohio LHD jurisdictions, and County Health Rankings and Roadmaps data on community characteristics

Figure ES.1. **Accreditation status of Ohio LHDs** (n=111)



*Data for the analysis in this study was obtained in November 2023. Since then, two more Ohio LHDs have become accredited. As of May 2024, 91 LHDs have been accredited and all but one are in the process of seeking accreditation.

Figure ES.2. **Population size and annual household income, by LHD accreditation status** (n=111)

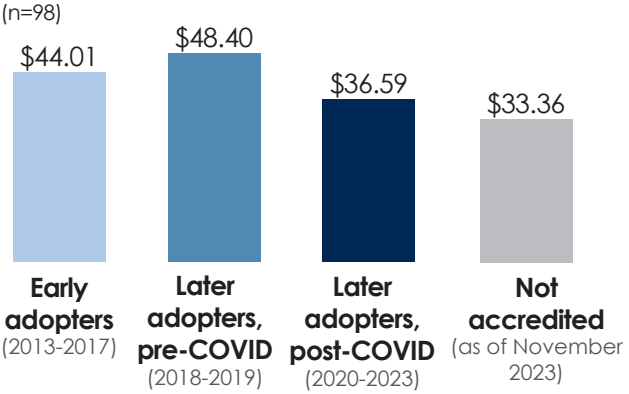


*County-level data (Ohio has 23 city LHDs. For these city LHDs, the data for this analysis is from the county in which the city is located.)
Sources: PHAB accreditation data, Association of Ohio Health Commissioners (population size for jurisdiction) and **2024 County Health Rankings and Roadmaps** (annual household income)

Key findings

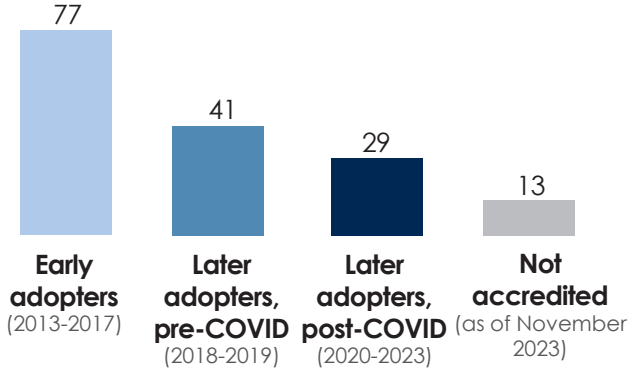
1. **Resources matter for PHAB accreditation.** LHDs in Ohio that achieved accreditation before 2020 typically serve larger populations and have somewhat higher per capita spending and more staff than those accredited later. LHDs that are not yet accredited are more likely to be in Appalachian counties and serve communities with lower median annual household incomes. The staff time required to pursue accreditation is significant. Differences in staff sizes among LHDs are a major factor driving disparities in accreditation status across the state.
2. **Culture matters for PHAB accreditation.** The decentralized structure of Ohio's public health system (Ohio is a "local control" state) and mistrust of state policymakers initially led to resistance to Ohio's accreditation mandate. LHDs that had staff and leadership who viewed accreditation as an opportunity for innovation and quality improvement were more likely to embrace the accreditation process and implement meaningful changes as a result. Local community conditions also affect the extent to which LHDs embrace accreditation. For example, some LHDs report difficulties implementing PHAB requirements due to perceptions related to equity, harm reduction and other evidence-based approaches.
3. **Performance management is a major benefit of accreditation.** The accreditation process has pushed LHDs to engage in quality improvement in new ways. Almost 100% of NORC survey respondents reported that accreditation has stimulated quality and performance improvements. Focus group participants enthusiastically recalled new ways that their agencies have strengthened their focus on outcomes and quality.

Figure ES.3. **Per-capita spending on all public health activities for Ohio LHDs, by accreditation status, SFY 2021 and 2022** (n=98)



Source: SFY 2021 and 2022 Annual Financial Report

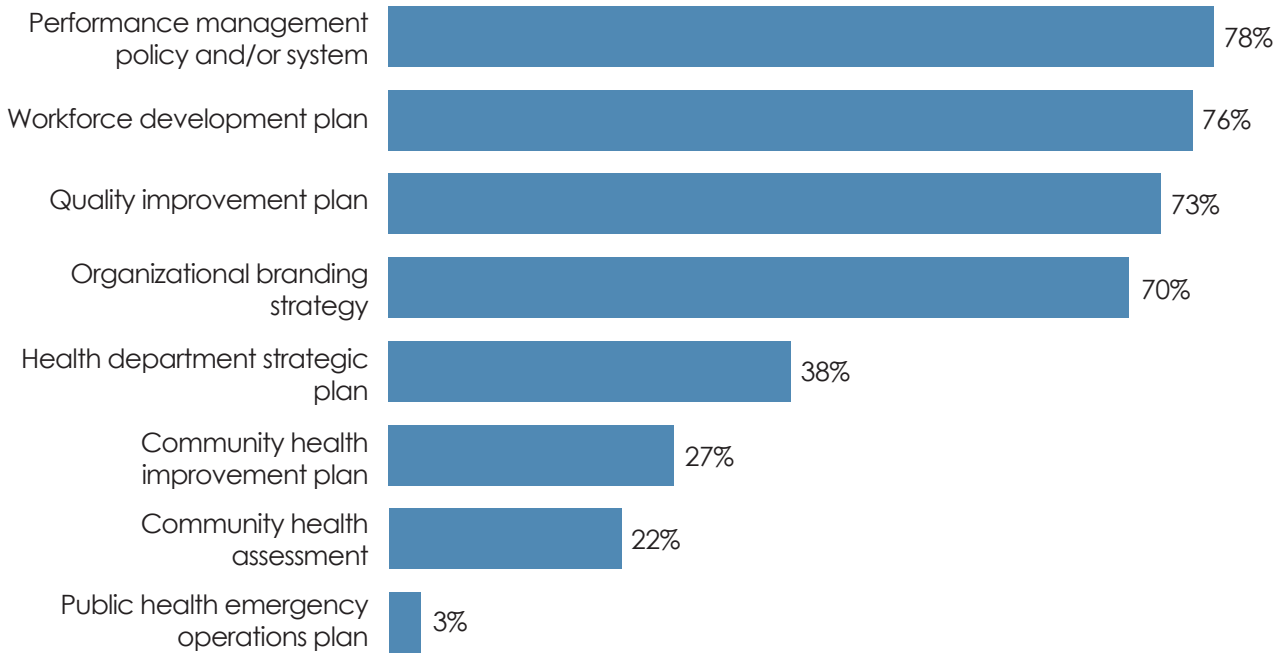
Figure ES.4. **Average full-time equivalent (FTE) staff for Ohio LHDs, by accreditation status, SFY 2021 and 2022** (n=90)



Source: SFY 2021 and 2022 Annual Financial Report

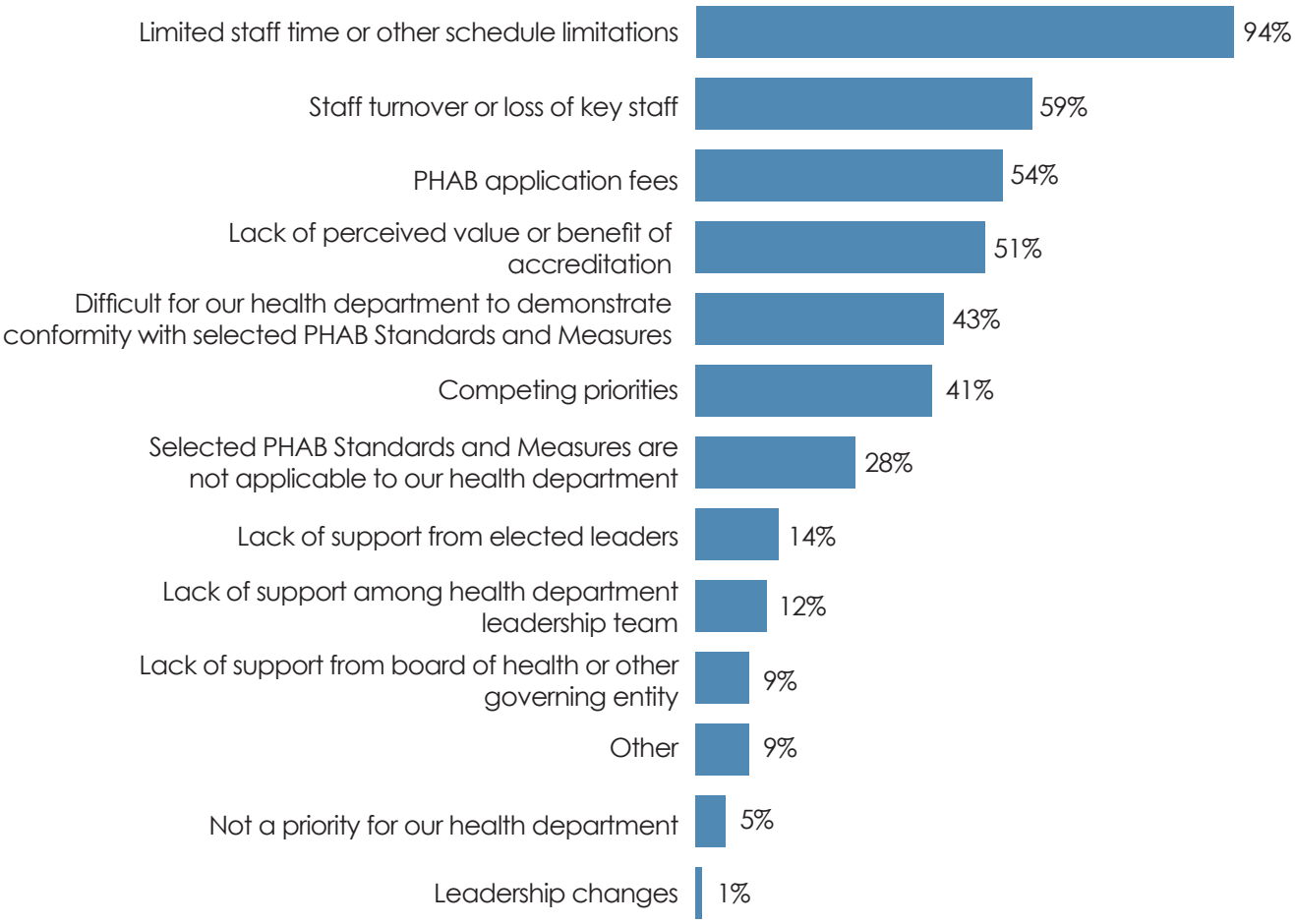
4. **Standardization, communications and collaboration are also major benefits of accreditation.** Many focus group participants emphasized that the standardization of policies, practices and documents required by accreditation has led to more efficient and effective resource use. Many also noted improvements to communications, such as branding strategies and consistent messaging, as well as stronger relationships with community partners.
5. **Cost is a major challenge.** Public health stakeholders report that cost is the biggest challenge to accreditation and emphasize that the staff time needed to manage and implement the process is the most significant cost driver (more than the PHAB fees). When asked about challenges experienced during the application process, NORC survey respondents identified limited staff time and staff turnover as the most common concerns (as displayed in figure ES.6.).
6. **Accreditation promotes a stronger focus on equity, but a broader view of equity and more guidance is needed.** Many LHDs report that the accreditation process has strengthened their approach to equity. For example, 80% of NORC survey respondents agreed or strongly agreed that their department has applied health equity to internal planning, policies or processes as a result of accreditation. Frustration with the perceived lack of clarity about "what counts" as acceptable equity activities, particularly for LHDs in predominantly white or rural communities, explains some of the lack of progress in this area.
7. **State Health Assessment/State Health Improvement Plan (SHA/SHIP) and Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) requirements set the stage for more coordinated and effective population health strategies.** The SHA/SHIP and CHA/CHIP requirements are widely seen as a valuable tool to drive coordinated, cross-sector efforts to improve population health and equity. However, most focus group participants agreed that the vision for collaboration and alignment has not yet been fully realized due to pandemic disruptions, lack of resources and barriers to effective LHD-hospital collaboration on assessments and plans.
8. **State and local policymakers have different perspectives on the value of accreditation.** State leaders emphasize the value of increasing consistency across LHDs and describe a vision for how widespread accreditation can lead to increased investments in public health. LHD representatives, on the other hand, express negative or mixed views of the mandate and have a nuanced understanding of the costs and benefits of accreditation. Concerns about state policymaker intent and lack of resources have fueled skepticism.
9. **PHAB has opportunities to improve the accreditation process**. Focus group participants expressed concern with three aspects of PHAB's performance: Slow response times (particularly during the pandemic), site visitor inconsistencies and academic jargon. In addition, they discussed ways the PHAB documentation requirements lead to administrative burden that in some cases complicates community partnerships and crowds out other activities.

Figure ES.5. **Percent of respondents who developed documents, plans or systems for the first time to prepare for accreditation** (n=36)



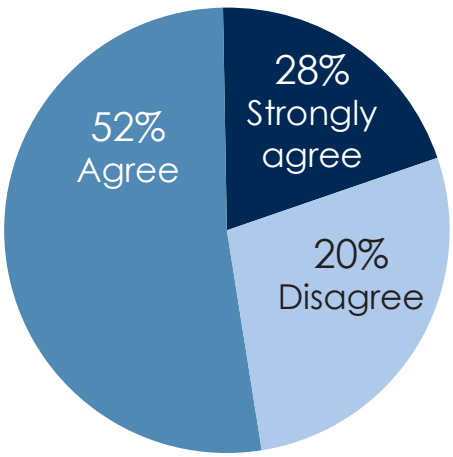
Source: NORC accredited survey

Figure ES.6. **Challenges experienced in the accreditation process** (n=95)



Source: NORC applicant survey

Figure ES.7. **As a result of accreditation, our health department has applied health equity to internal planning, policies, or processes** (n=25)



Source: NORC post accreditation survey

Recommendations for other states

- **Purpose, trust and transparency.** States should take time to build consensus among state and local public health partners about the purpose of accreditation and the goals of any policy changes designed to increase accreditation. These goals should be well-communicated and reinforced by efforts to maintain or strengthen trust, alignment and coordination between state and local leaders.
- **Jurisdiction population size.** States should be aware that small LHDs may struggle to achieve accreditation. Policymakers should clarify and communicate which of the following approaches will be taken for departments serving smaller jurisdiction population sizes:
  - If the goal is consistent capacity and quality across LHDs, regardless of size, then provide funding, technical assistance and other support to smaller LHDs to ensure success.
  - If the goal is efficiency and a flexible approach to accreditation that allows for variation in LHD capacity and quality, keep accreditation optional and/or allow for completion of PHAB's **Pathways Recognition Program**.
  - If the goal is to reduce the number of LHDs through mergers, then reach consensus between state and local partners on the best way to accomplish that goal.
- **Incentives.** States should consider incentives and guidance to encourage LHDs to seek accreditation. Local public health stakeholders emphasize that carrots may be more effective than sticks for getting LHDs to buy into the accreditation process and embrace meaningful changes to improve performance.
- **Funding.** States should be realistic and explicit about the extent to which accreditation will result in increased funding for LHDs. Intentional planning and policy change are needed to ensure that there are specific mechanisms accredited LHDs can rely upon to increase revenue needed to maintain accreditation status and implement evidence-based programs and services.
- **Technical assistance.** States should develop a robust and permanent infrastructure for training, technical assistance and peer-to-peer sharing. Learning communities and document templates are valuable tools, and better access to local data for CHAs is needed.
- **Workforce.** States should integrate accreditation-process-related skills into their public health workforce development efforts. The need for state funding to support the public health workforce will likely increase as pandemic-era federal funding ends.
- **Equity.** States should provide training and coaching for rural LHDs to increase understanding of the many ways that they can work towards more equitable communities, including activities tailored to engage and meet the needs of people with low incomes, people with disabilities, veterans, immigrants and other groups.

Recommendations for PHAB

- **Practice-based guidance and language.** Increased guidance to LHDs from PHAB on how to translate and apply the academic terminology of the current standards and measures would be helpful. For future versions, PHAB should use more plain and practice-based language.
- **Equity.** PHAB should clarify its definitions of equity, disparities and inequities and provide guidance on what equity means in a variety of communities, including examples relevant for LHDs in rural and Appalachian areas and in predominantly white communities.
- **Revisions to decrease administrative burden and strengthen positive impact.** Future versions of the PHAB standards and measures would be improved by:
  - An assessment of the meaningfulness, utility and expected outcome of each measure, based on research and practice-based evidence.
  - Streamlined documentation requirements that focus on activities with clear evidence of positive impact.
  - Eliminating requirements that have low or potentially harmful impact, including low-value activities that may drain department resources away from more constructive activities.
- **SROI analysis.** To better understand the costs and benefits of accreditation, PHAB (or another national or state entity) should fund a complete SROI analysis, using the outcome mapping in Appendix B as a place to start. Quantification of all costs and benefits associated with accreditation should inform policymaker decisions about accreditation-related support and requirements.

This report was prepared by the Health Policy Institute of Ohio under contract with the Public Health Accreditation Board (PHAB).