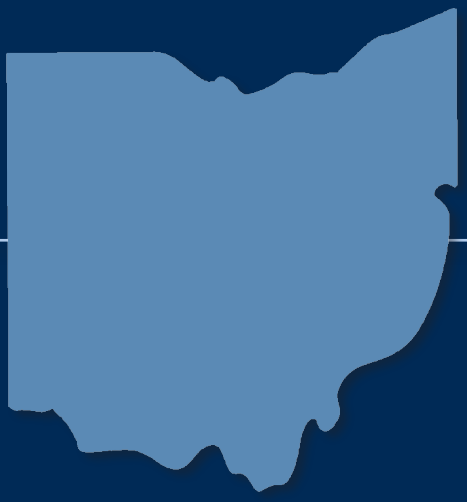
TELLING THE STORY OF PUBLIC HEALTH ACCREDITATION IN OHIO



health policy institute of ohio

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Acknowledgments

The Public Health Accreditation Board (PHAB) contracted with the Health Policy Institute of Ohio (HPIO) to conduct this study. HPIO staff and subcontractors designed and implemented the study based on research questions developed by PHAB.

HPIO thanks the many Ohio public health stakeholders who contributed to this project through focus groups and key informant interviews, as well as by providing feedback on study design and the final report. The Association of Ohio Health Commissioners (AOHC) and the Ohio Department of Health assisted with focus group recruitment.

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ACRONYMS

ANOVA: Analysis of variance

AFR: Annual Financial Report

ALC: Accreditation Learning Community

AOHC: Association of Ohio Health Commissioners

CDC: Centers for Disease Control and Prevention

CHA/CHIP: Community health assessment/community health improvement plan

CHNA(IS): Community health needs assessment (Implementation strategy)

CQI: Continuous quality improvement

FPHS: Foundational public health services

FTE: Full-time equivalent

HPIO: Health Policy Institute of Ohio

LHD: Local health department

MLC2: Multi-State Leaning Collaborative Grant

NACCHO: National Association of City and County Health Officials

NORC: A research organization at the University of Chicago (previously the National Opinion Research Center)

OAC: Ohio Administrative Code

ODH: Ohio Department of Health

OPHP: Ohio Public Health Partnership

ORC: Ohio Revised Code

PHAB: Public Health Accreditation Board

QI: Quality improvement

RWJF: Robert Wood Johnson Foundation

SFY: State fiscal year

SHA/SHIP: State Health Assessment/State Health Improvement Plan

SROI: Social return on investment

21C: 21st Century Learning Community

EXECUTIVE SUMMARY

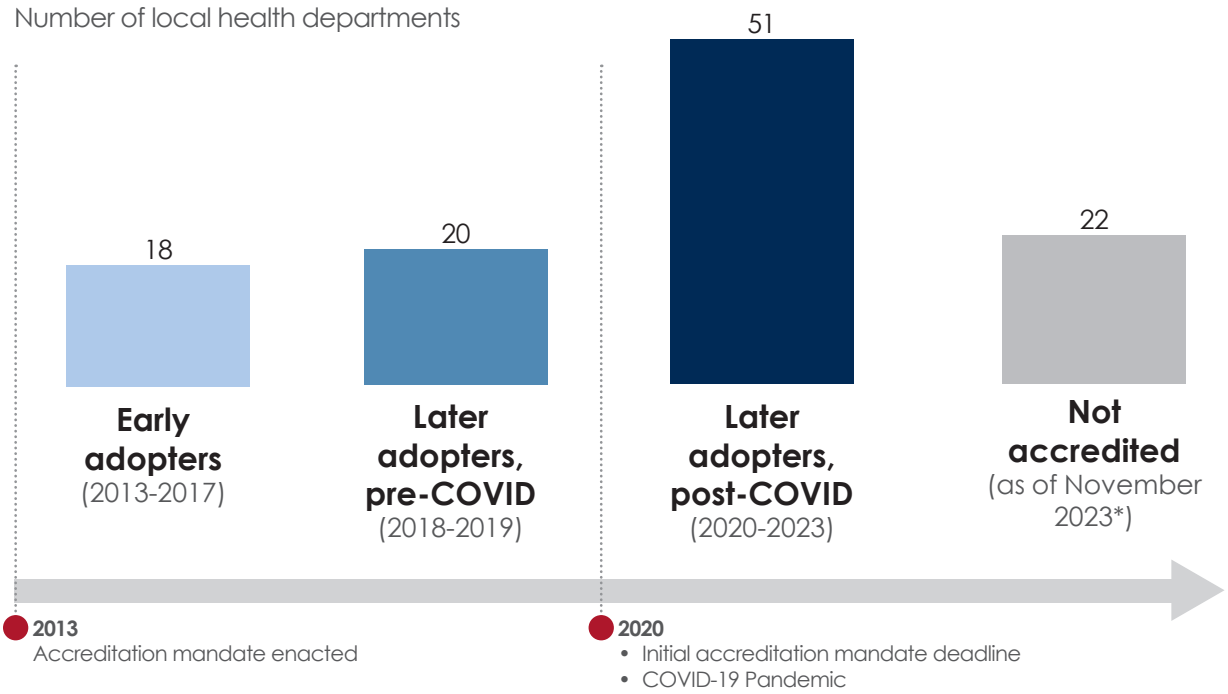
About this study

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:

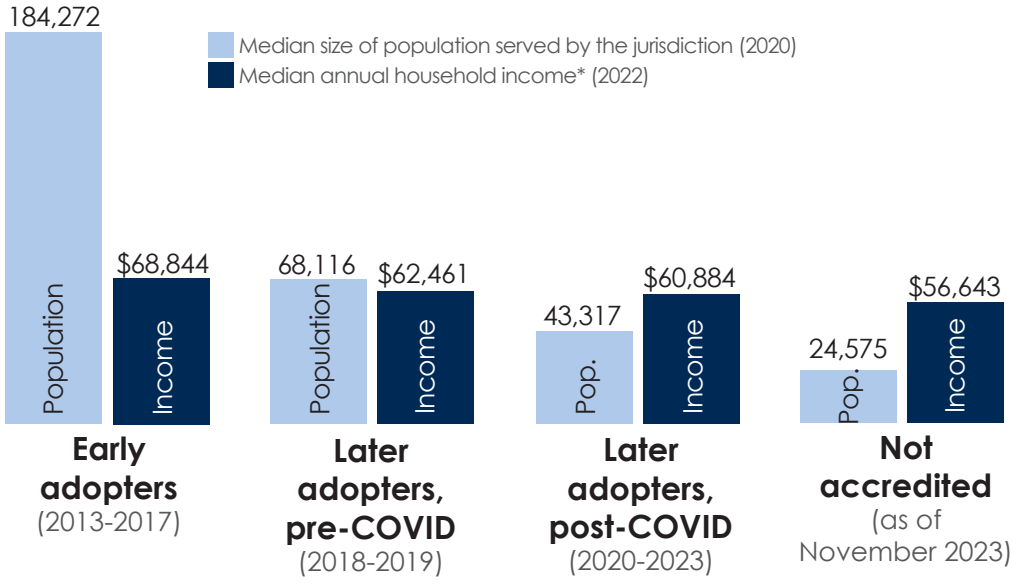
- **Focus groups:** Five groups with state and local public health leaders, including representatives from accredited and non-accredited LHDs (41 participants)
- **Key-informant interviews:** Interviews with public health leaders regarding the 21st Century public health grant (2 participants)
- **Social 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)

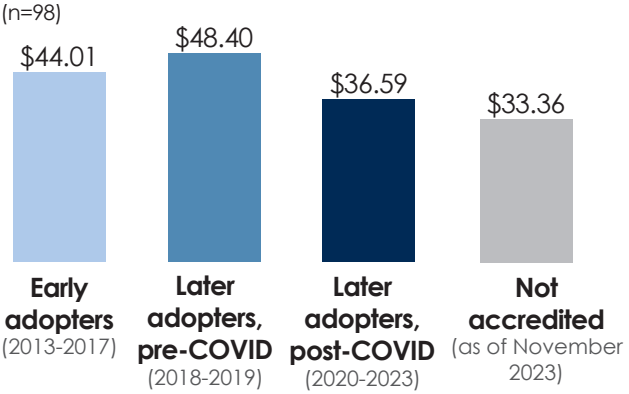


*County-level data (Ohio has 23 city LHDs. For these city LHDs, the data for this analysis is from the county in which the city is located.)
Sources: PHAB accreditation data, Association of Ohio Health Commissioners (population size for jurisdiction) and **2024 County Health Rankings and Roadmaps** (annual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

Key findings

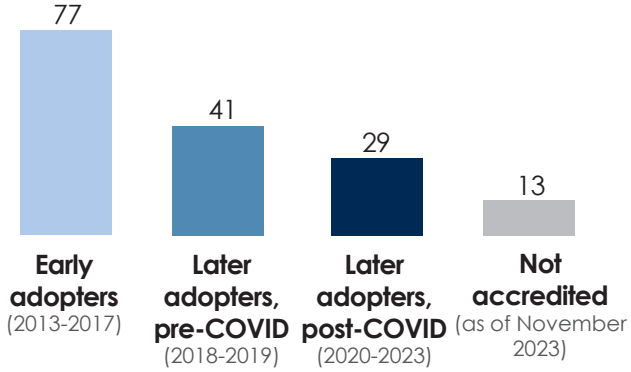
1. **Resources matter for PHAB accreditation.** LHDs in Ohio that achieved accreditation before 2020 typically serve larger populations and have somewhat higher per capita spending and more staff than those accredited later. LHDs that are not yet accredited are more likely to be in Appalachian counties 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

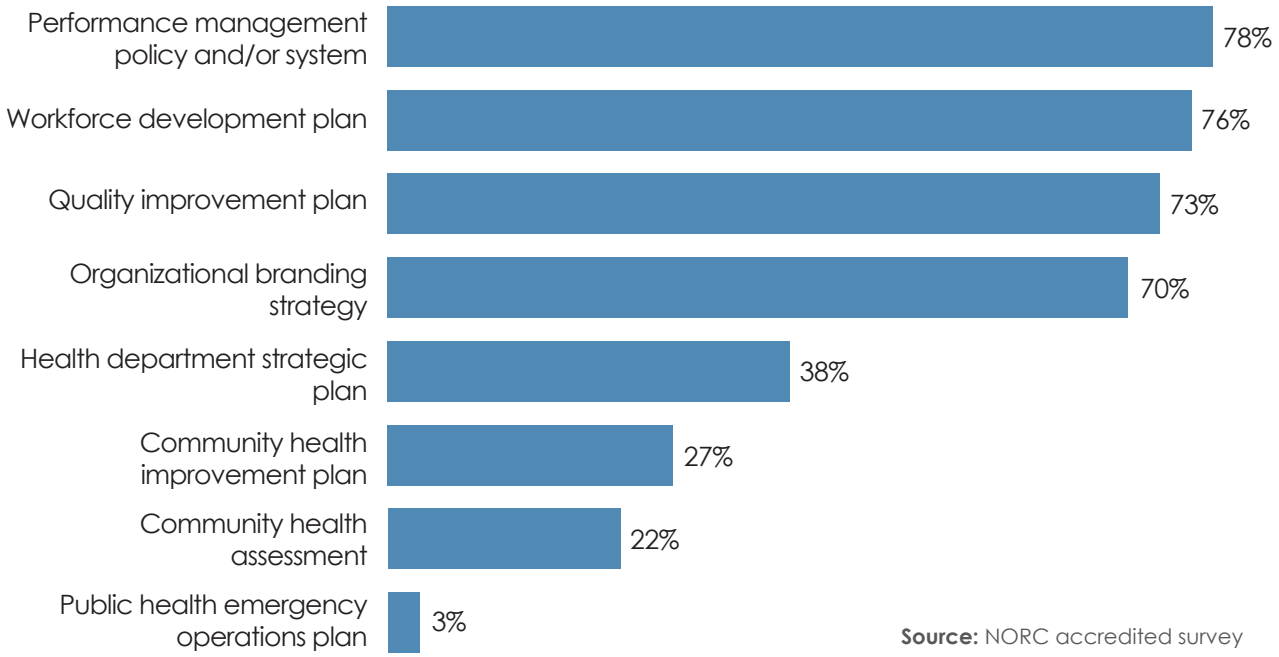
Figure ES.4. **Average full-time equivalent (FTE) staff for Ohio LHDs, by accreditation status, SFY 2021 and 2022** (n=90)



Source: SFY 2021 and 2022 Annual Financial Report

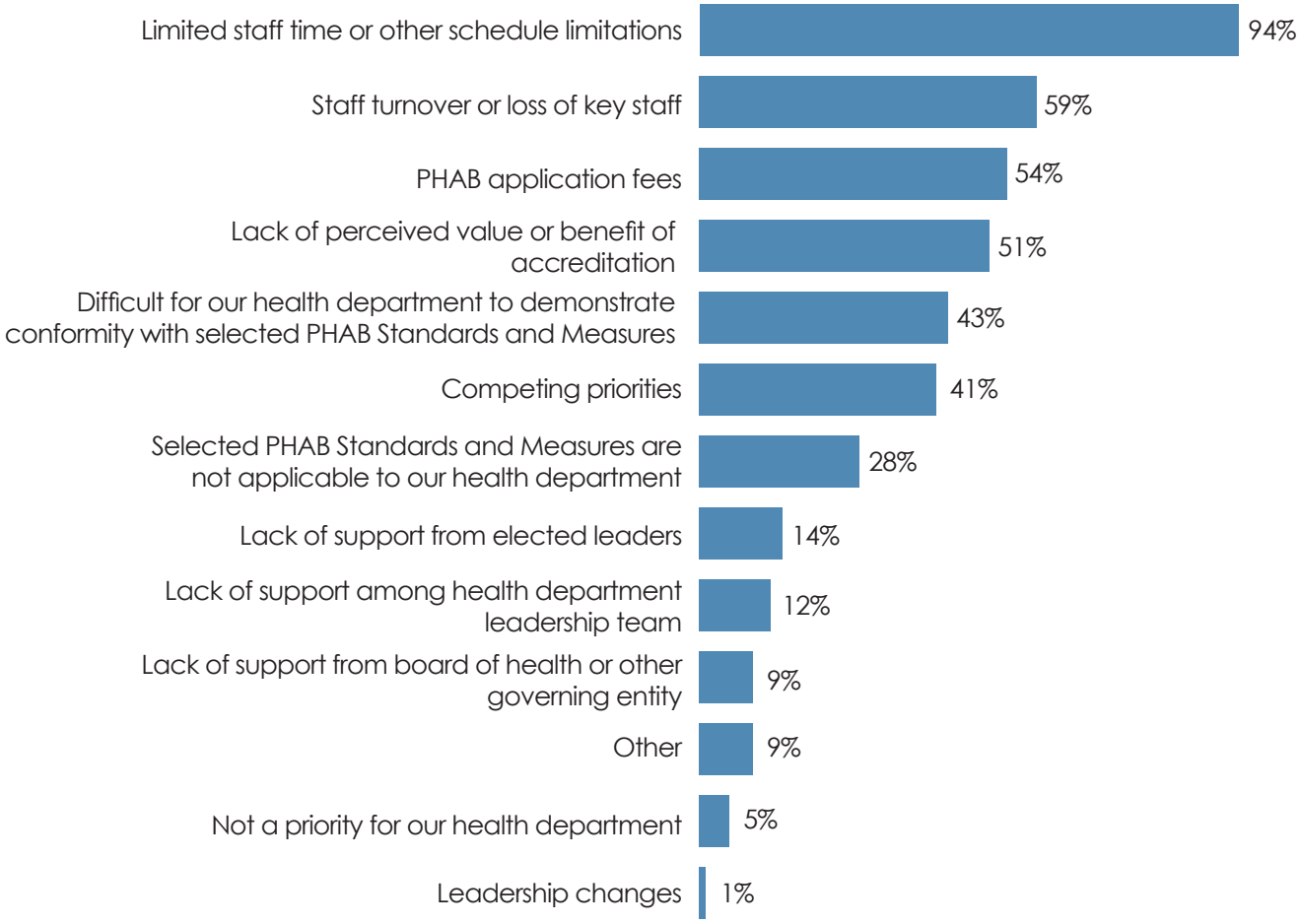
4. **Standardization, communications and collaboration are also major benefits of accreditation.** Many focus group participants emphasized that the standardization of policies, practices and documents required by accreditation has led to more efficient and effective resource use. Many also noted improvements 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)



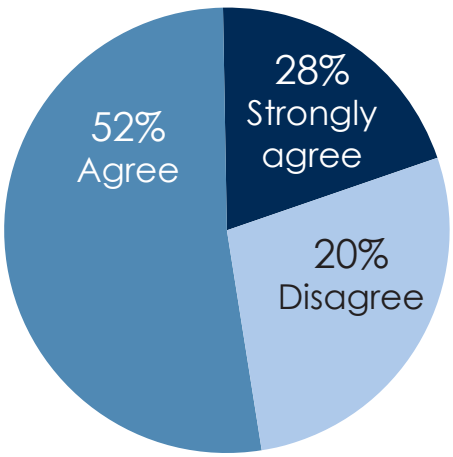
Source: NORC accredited survey

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.

PART 1 PURPOSE AND METHODS

Ohio has a higher percentage of local health departments (LHDs) that have achieved Public Health Accreditation Board (PHAB) accreditation than any other state.[2] The gradual adoption of accreditation in Ohio starting in 2013 provides a rich opportunity to compare experiences and outcomes for "early adopters," more recently accredited LHDs and LHDs not yet 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 was designed to answer the research questions listed in figure 1.1. This report is organized into sections that address each of these questions, synthesizing findings from relevant data sources.

Figure 1.1. **Research questions**

Research question	Report section
Current landscape. How do organizational and community characteristics of LHDs differ based on their accreditation status?	**Part 3**
Impact. What impact has accreditation had on individual LHDs within Ohio?	**Part 4**
Systems change. How has the public health system, as a whole, transformed as a growing proportion of LHDs in the state have achieved accreditation?	**Part 5 and Appendix D**
Equity context. How do cultural context and historical and structural factors affect participation in the accreditation process?	**Part 6**
Equity impact. In what ways are accreditation and the accreditation requirement likely to affect equitable distribution of public health resources across the state and disparities in health outcomes?	**Part 7**
Return on investment. What inputs, outputs and outcomes should be measured in order to assess the Social Return on Investment (SROI) of accreditation of LHDs?	**Part 8 and Appendix B**
Lessons learned. What lessons can be learned from the Ohio experience that could be applied to other states considering strategies to incentivize accreditation within the state?	**Part 9**
21st Century Learning Community (21C). How have accreditation and participation in 21C worked together to support public health system transformation?	**Appendix C**

Methods and data sources

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 (41participants; groups listed in figure 1.2)
- **Key-informant interviews:** Interviews with public health leaders regarding the 21st Century public health grant (2 participants)

- **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 (a research organization at the University of Chicago) for PHAB (2013-2022). (surveys listed in figure 1.3)
- **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

It is important to note that the data sources used in this study had different data collection formats, audiences, timing, purpose and limitations. In some cases, these differences led to slightly different conclusions. For example, the qualitative focus group findings often provided a more nuanced understanding of the impact of accreditation compared to the quantitative NORC survey findings.

Figure 1.2. **Focus groups**

Group	Number of participants
State level (purposive sample)	
1. State government leadership (current and former legislative and executive branch leaders)	8
2. Representatives of statewide public health associations and universities	9
Local level (LHDs) (stratified random sample)	
3. Early adopters of accreditation (and/or reaccreditation) (initial accreditation in 2013-2017)	8
4. Accredited later (initial accreditation in 2018-2023)	7
5. Not currently accredited	9

Figure 1.3. **NORC surveys**

Survey type	Accreditation timing	Number of Ohio respondents
1. Applicant survey	Applicant health departments that have registered their intent to apply for initial accreditation, prior to attending the PHAB accreditation training.	97
2. Accredited survey	Health departments shortly after they achieved initial accreditation.	70
3. Post accreditation survey	Accredited health departments approximately one year after the initial accreditation decision.	49
4. Year 4 accreditation Survey	Accredited health departments approximately four years after the initial accreditation decision, as they approached reaccreditation.	24
5. Reaccreditation survey	Health departments shortly after they achieved reaccreditation.	8

PART 2 BACKGROUND

Ohio is a local-control state and has a decentralized public health system. Ohio ranks 34th for per capita state public health funding (2021) and 48th for the number of state public health workforce per 100,000 population (2019).3 Most local health department (LHD) revenue comes from local sources. The state subsidy from the Ohio Department of Health (ODH) to LHDs is less than 1% of LHD revenue.[4] Half of Ohio LHDs serve population sizes under 50,000 (56 of 111 LHDs based on 2020 jurisdiction population size).

Since 2012, there have been several efforts to strengthen Ohio's public health infrastructure, including a series of "Public Health Futures reports" issued by the **Association of Ohio Health Commissioners (AOHC)** and **legislative committees**, as well as initiatives led by the **Ohio Public Health Partnership (OPHP)**. Figure 2.1 highlights key events and publications.

This time period has been marked by widespread turnover in the public health workforce at the state and local levels. For example, from 2011 to 2024, there have been nine directorships at ODH, serving Governors Kasich and DeWine.[5]

Accreditation policies

From 2013 to 2021, state policymakers, including the executive and legislative branches, used a number of policy levers to advance accreditation. As a result, the Ohio Revised Code contains the following:

- **Authority to mandate accreditation:** The Director of Health may require all local health districts to apply for accreditation by July 1, 2018 and to become accredited by July 1, 2020 as a precondition to receive funding from ODH (**ORC 3701.13** effective 2013)
- **Reporting requirements:** LHDs are required to meet minimum standards, including reporting on accreditation preparation and application efforts (**OAC 3701-36-03 as authorized by ORC 3701.342**, adopted in 2013 and 2014)
- **CHA/CHIP timing alignment:** Local health departments were required to submit existing community health assessments (CHAs) and Community Health Improvement Plans (CHIPs) to ODH by July 1, 2017, and to begin aligning on a three-year planning cycle starting Jan. 1, 2020, with initial reporting due Oct. 1, 2020 (**ORC 3701.981**, effective 2016)
- **City health department accreditation:** Cities with a population less than 50,000 whose city health district is accredited by Dec. 31, 2025, are exempt from a requirement to complete a study evaluating the efficiency and effectiveness of merging with the general health district (**ORC 3709.012**, effective 2021)

In addition, over the past decade, ODH leadership has clearly communicated the expectation that all LHDs become accredited. For example, ODH closely monitors each LHD's progress toward accreditation and has emphasized that failure to pursue accreditation could result in ineligibility for the state subsidy, as well as for state grants, including federal funding that is passed through ODH. As a result, almost all LHDs had entered the accreditation pipeline by the 2018 deadline by starting PHAB's preparation and readiness steps[6], although it took several years for many of them to achieve accreditation (often after 2020 due to pandemic-related disruptions).

Accreditation support and incentives

Local public health stakeholders in Ohio have long been active in national and state-level efforts to modernize public health and support accreditation.

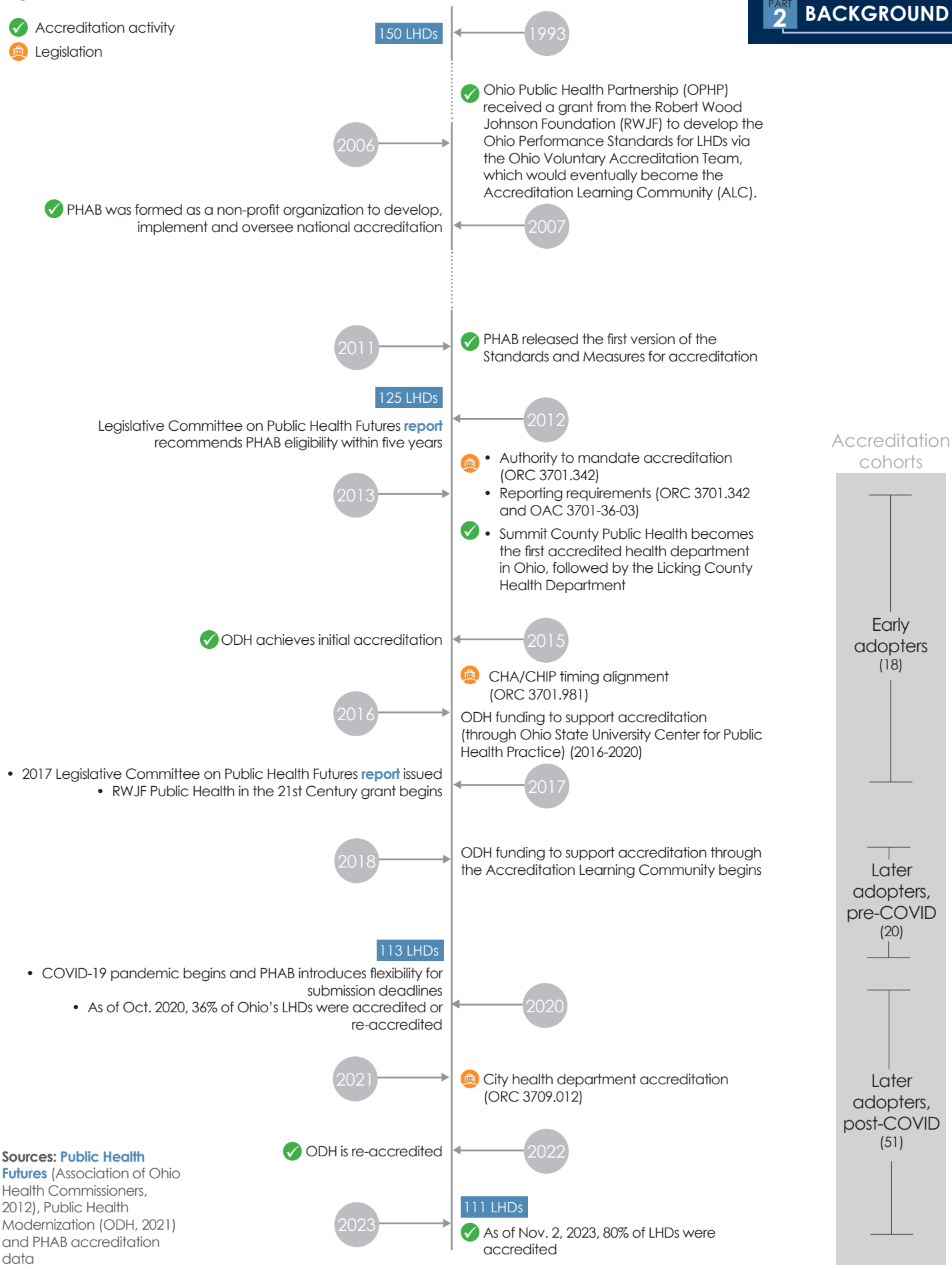
In 2006, the Ohio Public Health Partnership (OPHP) received a Multi-State Learning Collaborative (MLC2) Grant from the Robert Wood Johnson Foundation (RWJF). The grant facilitated the development of the Ohio Performance Standards for LHDs via the Ohio Voluntary Accreditation Team. This was the beginning of a years-long and evolving Accreditation Learning Community (ALC) administered by OPHP.

After the MLC2 grant ended, the ALC continued, along with mini grants to LHDs through the Strengthening Public Health Infrastructure for Improved Health grant from the Centers for Disease Control and Prevention (CDC). ALC meetings were held each year and featured national speakers on performance management, continuous quality improvement (CQI) training and "how to" guidance for the accreditation process. Starting in 2016, Ohio was among the first members of the 21st Century Learning Community (21C). See Appendix C for additional information about this initiative.

ODH has provided funding to LHDs to support and incentivize accreditation. For example:

- In 2016, ODH provided $1 million to LHDs to support completion of Community Health Assessments and Committee Health Improvement Plans (prerequisites for accreditation).
- From 2016-2020, ODH funded accreditation training and technical assistance through the Ohio State University Center for Public Health Practice.
- In 2018, ODH begin doubling the state subsidy for accredited LHDs (from $0.17 per capita to $0.34 per capita).
- In 2024, ODH announced that it will provide $25,000 to each LHD that is engaged in the accreditation process. This funding, which came from the CDC Public Health Infrastructure Grant, is intended to support initial accreditation, ongoing maintenance of accreditation, and reaccreditation.

Figure 2.1. **Timeline of accreditation-related activity in Ohio**



Sources: **Public Health Futures** (Association of Ohio Health Commissioners, 2012), Public Health Modernization (ODH, 2021) and PHAB accreditation data

How do organizational and community characteristics of LHDs differ based on their accreditation status?

LHD characteristics

As of November 2023[7], 89 of Ohio's 111 LHDs (80%) had achieved initial PHAB accreditation and 11 (10%) had also been reaccredited (see figure 3.1). Among accredited LHDs, 18 (20.2%) were early adopters accredited between 2013-2017, 20 (22.5%) were accredited in 2018-2019 and 51 (57.3%) were accredited in 2020-2023.

Figure 3.1 shows community characteristics that were found to correlate to accreditation status and timing.[8] Analysis of the differences between the four groups finds that non-accredited LHDs are significantly more likely to be in Appalachian counties and to serve lower-income areas with fewer residents, lower voter participation rates and higher proportions of non-Hispanic, white residents. These departments also serve counties that experience poorer health outcomes, such as lower life expectancy and higher rates of adult smoking.

Conversely, communities with LHDs accredited before 2020 are characterized by greater racial and ethnic diversity, higher civic engagement, better health outcomes and larger populations with higher incomes. Early adopters (accredited in 2013-2017) serve communities with the highest percentages of Hispanic residents, lower rates of adult smoking and higher life expectancies.

Figure 3.1. **Community characteristics, by LHD accreditation status** (n=111)

	Early adopters (2013-2017)	Later adopters, pre-COVID (2018-2019)	Later adopters, post-COVID (2020-2023)	Not yet accredited
Accreditation status				
Number	18	20	51	22
Percentage	16%	18%	46%	20%
% of accredited	20.2%	22.5%	57.3%	N/A
Demographic characteristics				
Median size of population served by the jurisdiction (2020)+	184,272	68,116	43,317	24,575
Median annual household income* (2022)+	$68,844	$62,461	$60,884	$56,643
Median voter participation rate* (2020)+	69.0%	66.1%	64.2%	62.1%
Number of LHDs (%) in Appalachian county*(2002)+	2 (11.1%)	3 (15%)	21 (41.2%)	15 (68.2%)
Median % of population Black* (2022)	4.87%	4.14%	2.36%	2.21%
Median % of population white* (2022)+	85.7%	86.8%	92.3%	92.2%
Median % of population Hispanic* (2022)+	4.5%	3.5%	2.1%	1.9%
Health factors and outcomes				
Median % of adults who smoke* (2021)+	18.6%	21.0%	21.6%	23.8%
Median life expectancy (years)* (2019-2021)+	76.0	75.7	75.6	74.3

*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.)
+Differences between groups were statistically significant based on an ANOVA analysis ($p<0.01$).
Source: PHAB accreditation data, Association of Ohio Health Commissioners (population size for jurisdiction) and **2024 County Health Rankings and Roadmaps** (for other community characteristics)

Annual financial report (AFR) findings

The AFR submitted by LHDs to the Ohio Department of Health (ODH) each year provides information about LHD spending on the **foundational public health services** (FPHS), as well as overall spending and spending on equity. The AFR also contains information about the perceived gap in investment in the FPHS (as reported by each LHD). Comparing the size of these gaps across LHDs is an indicator of consistency in public health capacity across the state. Lastly, the AFR provides the most complete source of data for LHD staffing levels.

Spending and investment gaps

Early adopters and pre-COVID later adopters reported somewhat higher per-capita spending on all public health activities and the FPHS than post-COVID later adopters and LHDs that are not accredited, yet none of these differences in spending were statistically significant (see figure 3.2). Early adopters reported somewhat lower per-capita investment gaps to fully implement the FPHS, yet the difference was not statistically significant. Finally, a closer look at LHDs' spending on equity revealed no association between PHAB accreditation status and per capita spending on equity.

Figure 3.2. **Per capita spending and investment gaps for Ohio LHDs, by accreditation status, SFY 2021 and 2022** (n=88-98)

	Early adopters	Later adopters, pre-COVID	Later adopters, post-COVID	Not yet accredited
Per-capita spending on all public health activities	**$44.01** ($38.54 - $71.90)	**$48.40** ($40.25 - $51.61)	**$36.59** ($26.64 - $62.12)	**$33.36** ($26.36 - $49.38)
Per-capita spending on the FPHS	**$29.30** ($25.00 - $42.35)	**$29.14** ($23.00 - $38.79)	**$25.04** ($17.83 - $42.13)	**$24.90** ($19.22 - $35.82)
Per-capita investment gap to fully implement the FPHS	**$7.36** ($0.32 – $7.89)	**$10.58** ($8.58 - $15.91)	**$8.69** ($0.98 - $19.71)	**$8.76** ($2.55 - $13.07)
Per-capita spending on equity	**$0.25** ($0.23 - $0.55)	**$0.55** ($0.04 - $0.57)	**$0.26** ($0.00 - $0.51)	**$0.54** ($0.09 - $0.71)

Note: Due to missing data, the sample size ranged from 88/111 LHDs (79.3%) for per capita investment gap to fully implement the FPHS to 98/111 LHDs (88.3%) for per capita spending on all public health activities and per capita spending on the FPHS. Table shows medians with interquartile ranges in parentheses, weighted by population size. Analysis of variance (ANOVA) indicated no statistically significant differences in spending across accreditation status at $p<0.05$.
Source: SFY 2021 and 2022 Annual Financial Report

Staffing

Larger LHDs tended to pursue PHAB accreditation earlier than smaller LHDs. Early adopters reported employing an average of 76.6 full-time equivalent (FTE) staff compared to 40.9 FTEs for pre-COVID later adopters and 29.1 FTEs for post-COVID later adopters (see figure 3.3). LHDs not yet accredited reported an average of 13.1 FTEs. None of the differences in staffing across PHAB accreditation status, however, was statistically significant.

Figure 3.3. **FTE staff for Ohio local health departments, by accreditation status, SFY 2021 and 2022** (n=90)

	Early adopters	Later adopters, pre-COVID	Later adopters, post-COVID	Not yet accredited
FTE staff	**76.6** (43.4 – 105.4)	**40.9** (23.4 – 65.0)	**29.1** (17.9 – 36.0)	**13.1** (9.1 – 18.5)

Notes: Due to missing data, the sample size was 90/111 LHDs (81.1%). Table shows medians with interquartile ranges in parentheses, weighted by population size. Analysis of variance (ANOVA) indicated no statistically significant differences in FTE staff across accreditation status at $p<0.05$.
Source: SFY 2021 and 2022 Annual Financial Report

What impact has accreditation had on individual health departments within Ohio?

This section draws upon the focus group discussions and NORC survey results to explore ways that the accreditation process has affected health departments. Stakeholders praised positive changes related to performance management, quality improvement, collaboration and communications, but expressed concerns about high costs and the staff burden of accreditation-related "busy work." Participants expressed mixed views on whether accreditation improved the pandemic response and many noted that it is too soon to tell if accreditation will improve health outcomes.

Positive impact on health departments

Focus group participants and NORC survey respondents identified many ways that accreditation has benefited their health departments, including specific public health capabilities such as quality improvement, collaboration and communications. Additionally, standardization, organizational preparation and staff pride were positive themes identified. State leaders emphasized that widespread accreditation sets the stage for future investments in public health.

Specific public health capabilities

The 10 PHAB domains are comprehensive and address the **10 essential public health services** (listed in figure 4.1). Based on how frequently they were mentioned by focus group participants, however, three capabilities emerged as the most significant concrete benefits to health departments:

- Performance management, quality improvement and evaluation [domain 9]
- Collaboration and partner relationships [multiple domains]
- Communications [domain 3]

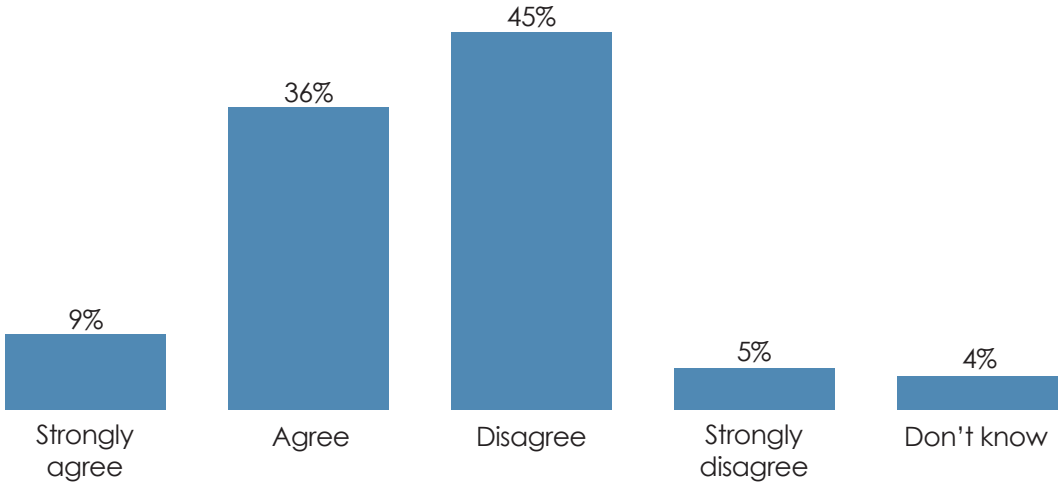
Figure 4.1. **PHAB domains** (Version 2022)

Domain 1	Assess and monitor population health
Domain 2	Investigate, diagnose and address health hazards and root causes
Domain 3	Communicate effectively to inform and educate
Domain 4	Strengthen, support and mobilize communities and partnerships
Domain 5	Create, champion and implement policies, plans and laws
Domain 6	Utilize legal and regulatory actions
Domain 7	Create, champion and implement policies, plans and laws
Domain 8	Build a diverse and skilled workforce
Domain 9	Improve and innovate through evaluation, research and quality improvement
Domain 10	Build and maintain a strong organizational infrastructure for public health

Performance management, quality improvement and evaluation

According to the NORC applicant survey, approximately 50% of respondents' health departments had not implemented quality improvement (QI) strategies before assessing readiness for accreditation (displayed in figure 4.2).

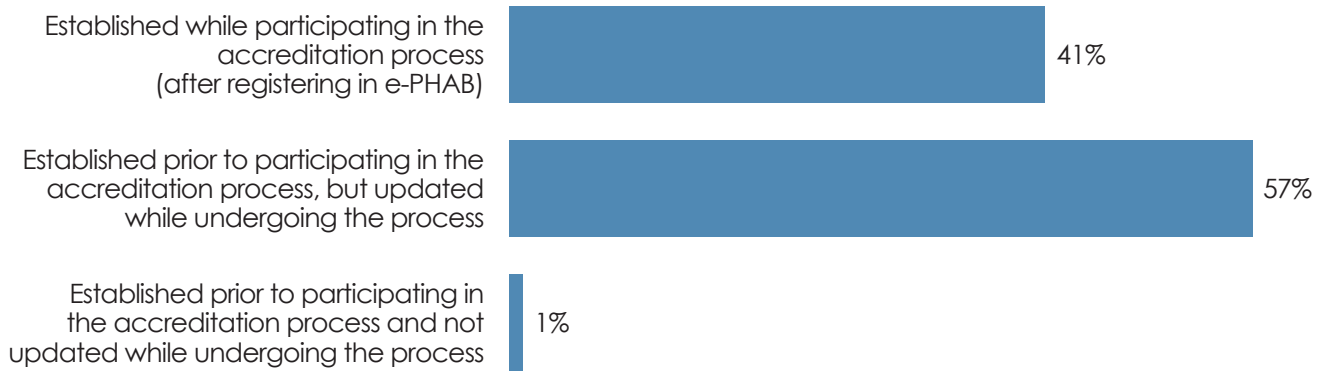
Figure 4.2. **Implementation of strategies for QI before assessing the health department's readiness for accreditation** (n=95)



Source: NORC applicant survey

Approximately 41% of respondents established an organization-wide process for QI while participating in the accreditation process, while an additional 57% had an organization-wide process prior to participating in the accreditation process that was updated during the process (displayed in figure 4.3).

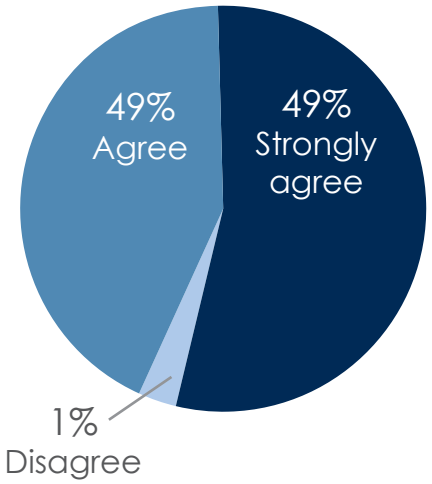
Figure 4.3. **Establishment of an organization-wide process for QI** (n=68)



Source: NORC accredited survey

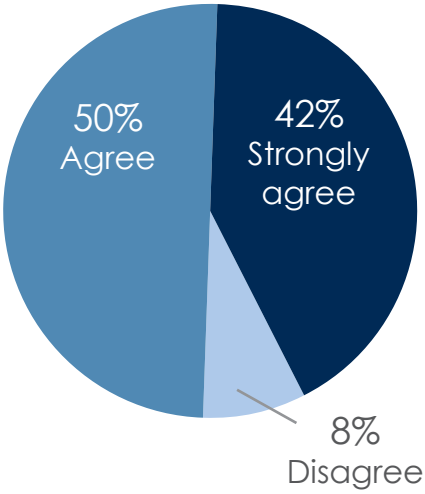
Figures 4.4. and 4.5 highlight that the majority of LHDs agreed that accreditation stimulated QI within their health department and strengthened the culture of QI in their health department.

Figure 4.4. **Accreditation has stimulated quality and performance improvement opportunities within our health department** (n=53)



Source: NORC post accreditation survey

Figure 4.5. **Accreditation has strengthened the culture of QI in our health department** (n=24)



Source: NORC year 4 accreditation survey

Focus group participants and NORC survey respondents frequently described ways that the accreditation process had pushed their agencies to engage in QI in new ways after working through domains 3 and 9:

> *"**We've put performance management into place statewide** on the state level as well as the local level. Frankly, I think people have embraced that."*
> *—State government leadership focus group*

> *"I think **we truly do strive for continuous quality improvement, and I think PHAB has really pushed us towards that mindset…** So I think that's the biggest advantage that we've seen come from [accreditation]."*
> *—Early adopters LHD focus group*

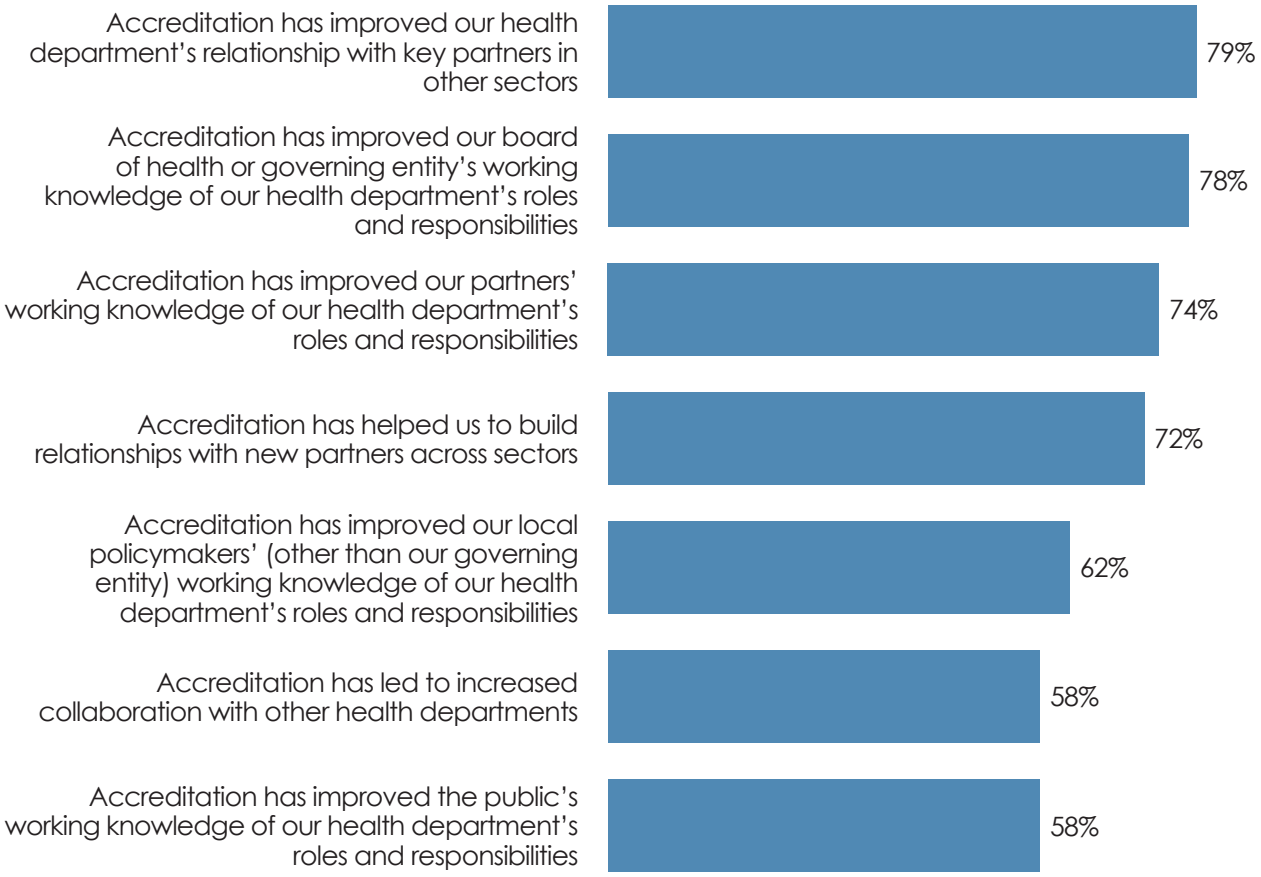
> *"While department leadership value QI, I don't think it would have been introduced and developed on the same timeline had it not been for accreditation. **Accreditation was a driving force**."*
> *—NORC Accredited LHD survey*

Collaboration and partner relationships

Comments about collaboration and partner relationships were more nuanced. Many participants stated that they had good relationships with external partners prior to accreditation and that the accreditation process may have encouraged them to strengthen them further. Some also noted that the COVID-19 pandemic led to improved partnerships, making it difficult to isolate the impact of accreditation versus the pandemic since they happened around the same time for many LHDs.

Accreditation also benefited collaboration within LHDs. While focus group and NORC survey respondents noted existing relationships before pursuing accreditation, 90% of NORC accredited survey respondents agreed or strongly agreed that undergoing accreditation stimulated greater collaboration across their LHD. Figure 4.6 shows additional impacts of accreditation on relationships with stakeholders.

Figure 4.6. **Accreditation's impact on relationships with stakeholders** (n=67)



Source: NORC accredited survey

> *"…some [LHDs] already had good relationships prior to the accreditation requirement, with their cross-sector partners, with their county elected officials, with their county commissioners. But with accreditation, **it pushes [more collaboration]**, … So, absolutely it helped."*
>
> *—State government leadership focus group*

> *"I will say that our partnerships were lukewarm before COVID. …It's hard to say whether PHAB helped us to ignite that partnership, but **it definitely helped us to strengthen that partnership we have with them [CHA/CHIP partners] now**. …I'm just getting a lot of positive feedback. So, I do think it's helping."*
>
> *—Not currently accredited focus group [in accreditation process]*

Communications

Many focus group participants mentioned that accreditation requirements had prompted them to adopt a more comprehensive and professional approach to communications, including use of branding strategies and consistent messaging.

> *"**We are doing better at communicating who we are**, what we do, why we do the things that we do. …we're pushing ourselves to be more visible. So, I think that that's something that's a benefit of PHAB."*
>
> *—Not currently accredited focus group [in accreditation process]*

Standardization and efficiency within departments

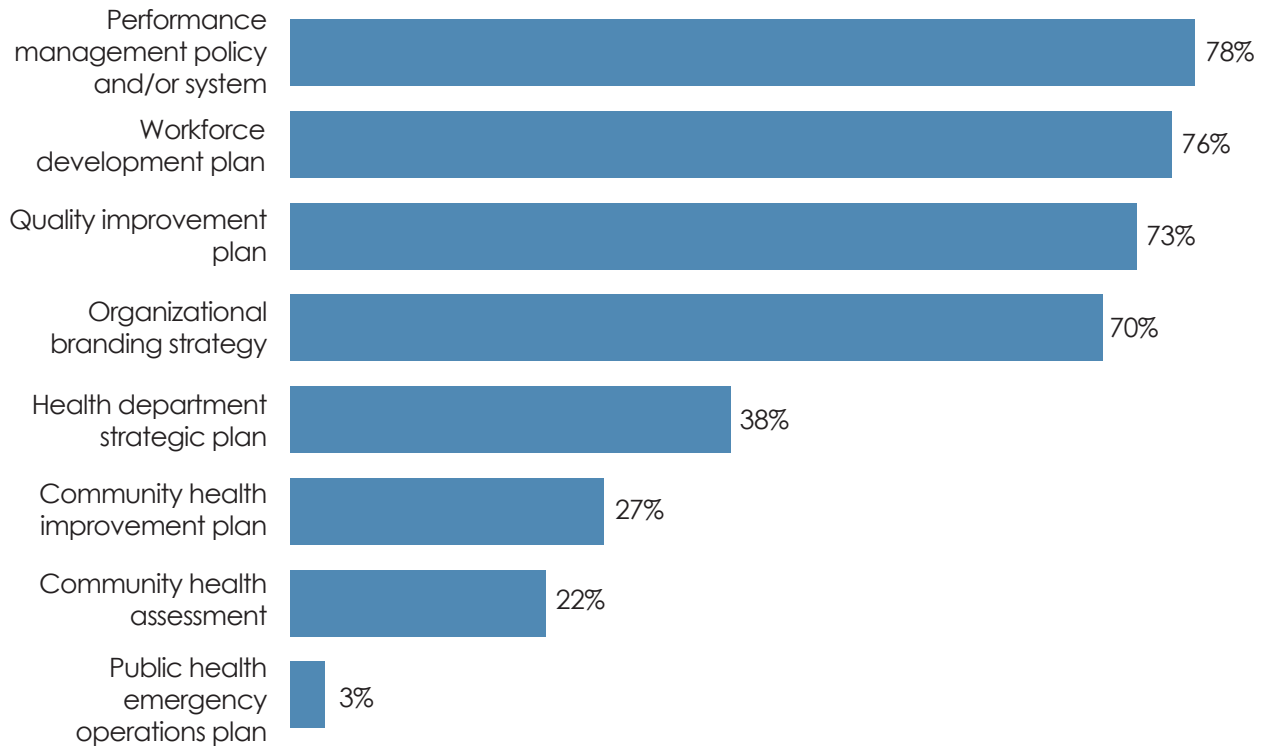
Many focus group participants emphasized that the standardization of policies, practices and documents required by accreditation has led to more efficient and effective resource use—a cross-cutting benefit affecting multiple domains. They recounted examples of how standardization has saved staff time by "not reinventing the wheel," provided continuity during times of high staff turnover and supported peer-to-peer assistance and staff sharing between and within LHDs.

> *"[before accreditation] there were a lot of things that you did because somebody knew how to do it, but it wasn't necessarily written down or part of an onboarding plan or training or anything like that. So I think **it formalized a lot of the work** which actually turned out to be very timely with the turnover that we had post COVID."*
>
> *—Statewide public health associations and universities focus group*

> *"…We didn't actually have [Standard Operating Procedures] or anything in place [before accreditation]. So, it made it **more streamlined**, especially for the smaller health departments when all of us have to do multiple things, we can easily pass off a procedure to somebody else and they can pick up the pieces."*
>
> *—Accredited later focus group*

Similarly, the NORC accredited survey shows that the majority of LHDs developed performance management policies or systems, workforce development plans and QI plans for the first time in preparation for accreditation (shown in figure 4.7).

Figure 4.7. **Percent of respondents who developed documents, plans or systems for the first time to prepare for accreditation** (n=36)



Source: NORC accredited survey

Funding opportunities

When discussing the benefits of accreditation, the state-level leadership focus group participants described a vision for how universal adoption of PHAB accreditation positions local public health to receive increased investments from the state legislature, hospitals, Medicaid and other partners. This vision involves three key components:

- Consistency across LHDs (all Ohioans have access to foundational public health services, regardless of where they live and investors "know what they are buying")
- Increased credibility and visibility of public health (investors turn to public health and "know they are buying a quality product")
- Well-coordinated and effective population health planning (investments in public health are strategic and will "move the needle" on population health priorities):
  - The SHA and SHIP set state-level population health priorities and drive collaboration and investment across state agencies
  - CHAs and CHIPs inform and align to the SHA and SHIP
  - Collaboration between LHDs and hospitals on CHAs, CHIPs, CHNAs and ISs

> *"From the administration standpoint, [accreditation] was a real opportunity just to make sure **wherever you were in the state,** you knew your public health district had enough **capacity to be able to get the job done.**"*
>
> *— State government leadership focus group*

> *"…speaking as a legislator at that time [when the authority for the ODH Director to mandate accreditation was established], **there was always a desire to fund public health a little more meaningfully out of the General Revenue Fund**. …[We were] trying to find a more universal platform that the state might actually be able to fund… across the state in a more equitable universe."*
>
> *—State government leadership focus group*

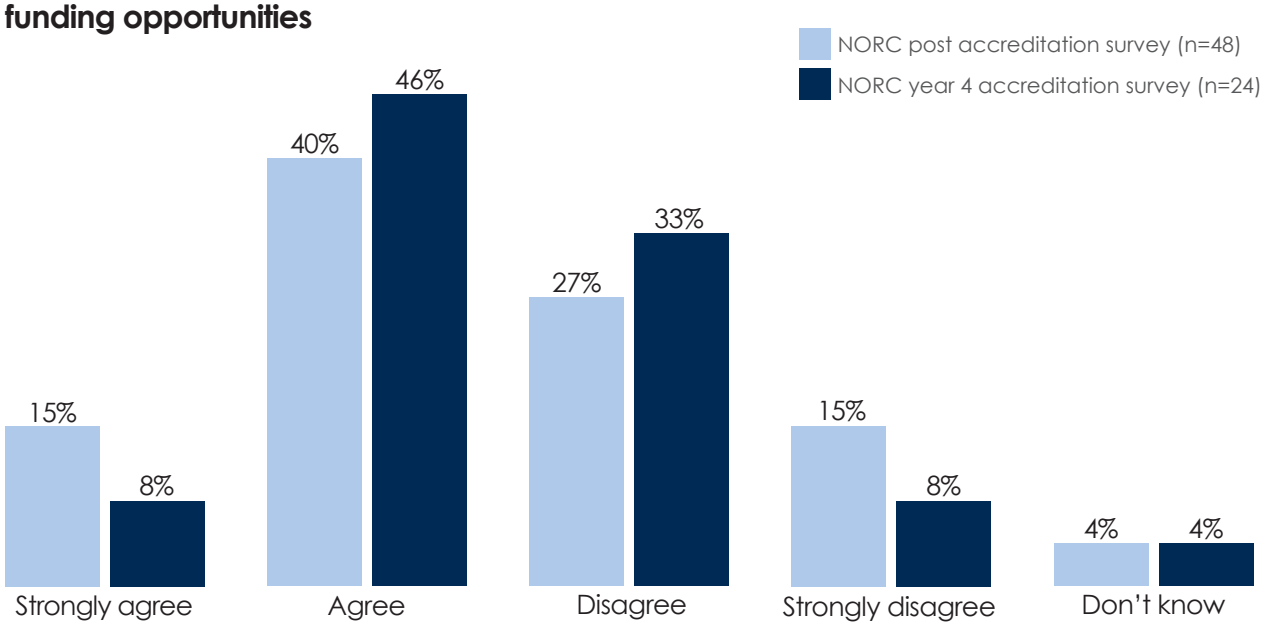
> *"…when I started 14 years ago, …we still had local [LHD] partners with paper ledgers. …**When [accreditation] requires you to come to a new level** …Nobody wants to be a partner with somebody that's not operating at a quality level."*
>
> *—State government leadership focus group*

Participants acknowledged that this vision has not yet come to full fruition, but are hopeful that the foundation has been set.

> *"…They can say 'Ohio is accredited, or this county is accredited, and we know they have good systems in place.' So, **we are hopeful that any investment in [accreditation now] reaps rewards in the future around funding and support**."*
>
> *—State government leadership focus group*

While a few focus group participants noted that accredited LHDs receive more subsidies from ODH, no other concrete financial benefits of accreditation were mentioned by LHD representatives. However, approximately half NORC post accreditation survey and year 4 accreditation survey respondents strongly agreed or agreed that accreditation has improved their LHD's competitiveness for funding opportunities (shown in figure 4.8).

Figure 4.8. **Accreditation has improved our health department's competitiveness for funding opportunities**



Source: NORC post accreditation survey and NORC year 4 accreditation survey

Staff pride

Increased staff pride was a common unanticipated benefit of accreditation mentioned by NORC survey respondents. This was especially true among smaller health departments.

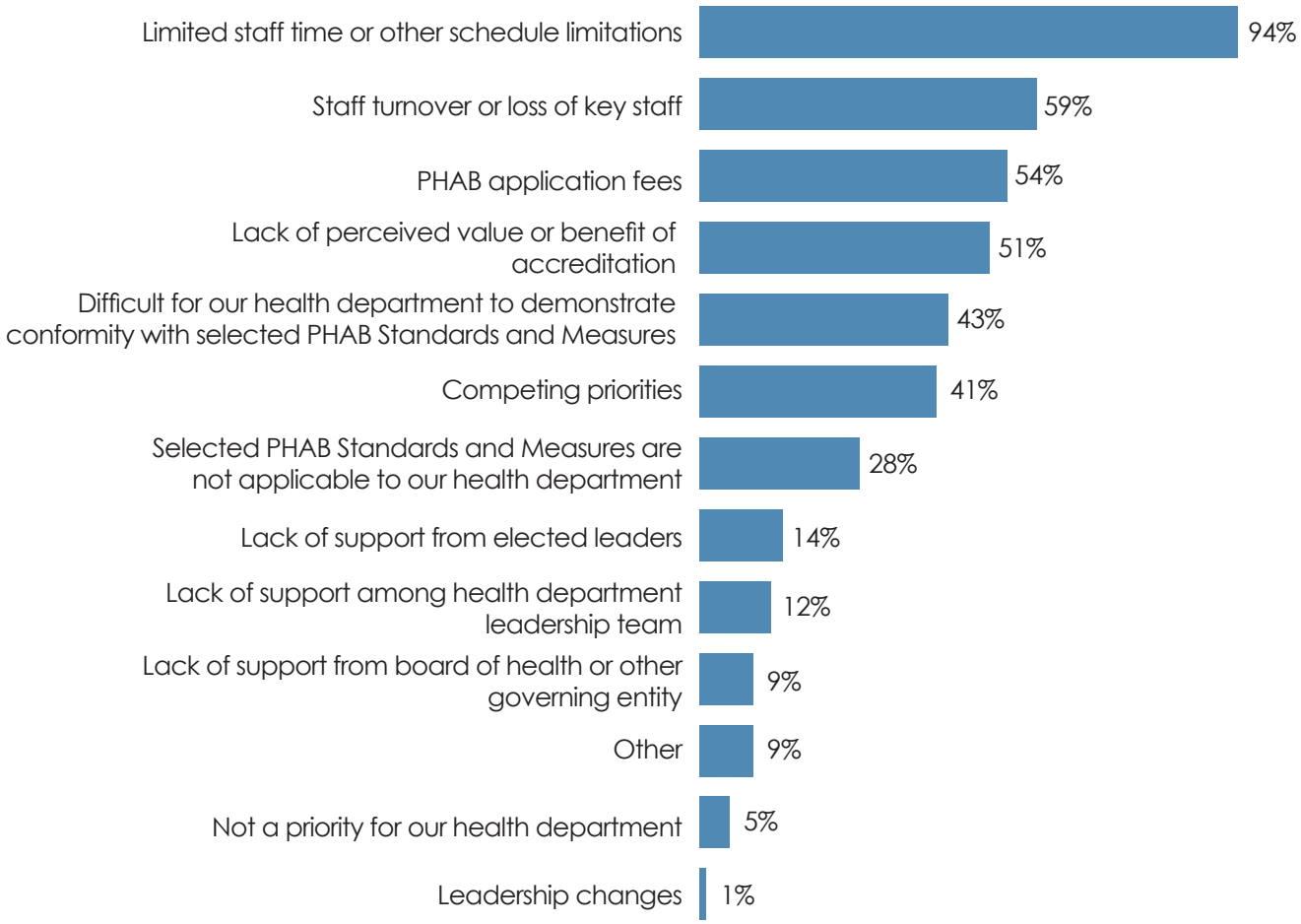
> *"Although we knew accreditation would make us a stronger health department, **we did not anticipate how much it would improve the morale and strengthen the pride among staff members**. Staff who were indifferent or resistant to accreditation at the beginning were excited and eagerly awaiting the results of the report after our site visit. We weren't expecting staff attitudes to change so much for the better."*
>
> *— NORC Accredited LHD Survey*

Negative impact on health departments

Focus group participants and NORC survey respondents also discussed ways that the accreditation process has been costly, difficult or has not led to intended impact. The leading themes are discussed below, including cost, staff burden, busywork and PHAB performance problems.

Staff time, application fees and competing priorities were similar findings from both the focus groups and NORC surveys. Figure 4.9 provides an overview of challenges that LHDs experienced during the accreditation process.

Figure 4.9. **Challenges experienced in the accreditation process** (n=95)



Source: NORC applicant survey

Cost

The most common concern expressed by focus group participants was the high cost of accreditation and its impact on LHDs' ability to provide services. Participants identified the following direct and indirect costs (described in more detail in Part 8):

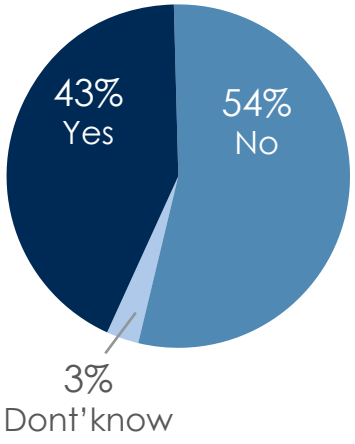
- PHAB application and annual fees
- Pre-requisite activities (CHA, CHIP and Strategic Plan), including the costs of collecting or purchasing data for the CHA, as well as for hiring consultants (if needed or feasible)
- Salary and benefits for the accreditation coordinator and/or accreditation consultant(s)
- Staff time to create and compile documents and policies, participate in accreditation-related training and meetings (mileage and hotel costs, in some cases), and other accreditation-related activities
- Lost revenue and opportunity costs due to staff spending time on accreditation tasks rather than fee-generating direct services and other services and programs

> *"Existing programs are **suffering due to the overall amount of time spent on accreditation** as a result of the mandate in Ohio to become accredited. Compressing the accreditation process into this timeline has also robbed us from some of the benefits that may have been achieved otherwise."*
>
> *— NORC Applicant LHD Survey*

> *"The **financial aspect of the process is overwhelming**. The hiring of a person to just do accreditation is what was necessary. I feel like we had to develop a workforce just for doing accreditation, and it can be too much."*
>
> *— NORC Applicant LHD Survey*

As shown in figure 4.10, 43% of NORC accredited survey respondents hired a consultant for assistance through the accreditation process.

Figure 4.10. **Percent of health departments that hired a consultant for the accreditation process** (n=37)



Source: NORC accredited survey

Staff burden for small LHDs

The second most frequently mentioned concern was the unique challenges faced by smaller LHDs. Many participants, particularly those from rural or smaller city health departments, asserted that it was an unfair burden to require small LHDs to submit the same amount of documentation as larger LHDs. While the PHAB annual accreditation service fees are adjusted by population size, the documentation requirements are the same for departments of all sizes. Participants emphasized that this results in a disproportionate burden of staff time (and therefore costs) for smaller departments.

> *"We have eight [staff] people. And we did the same amount of work that a very large department [did]. We did the same amount of work that the state health department did. We did the same amount of work that county health departments did with eight people. So while a lot of times I gripe about the economy of scale,* ***it's not fair that we had to do the same amount*** *of work with the less number of people. I'm pretty darn proud that we did the same amount of work as departments that have entire staff devoted to accreditation."*
>
> *— Not currently accredited focus group [in accreditation process]*

> *"I don't think a* ***one size fits all...it doesn't work****. I've seen that during site visits as a site visitor."*
>
> *— Early adopter LHD focus group*

> *"****Due to our size and culture of daily implementation of informal QI, the formalized, over-developed QI plan caused unnecessary complexity*** *to agency improvements that cost time and money of a frustrated staff. Our QI plan needs simplified to match our routine and more successful organic QI culture that existed prior to the accreditation process."*
>
> *— NORC Accredited LHD Survey*

> *"We are a 12-person--Twelve!!—county health department, and we are trying hard to meet accreditation standards as mandated by Ohio Department of Health. It is* ***very, very difficult*** *in spite of the good changes that occur during the process."*
>
> *— NORC Applicant LHD Survey*

Administrative burden

Many participants described some aspects of the accreditation process as "busy work" that has little value and adds to staff time burden. There was a general consensus that some measures and documentation requirements are meaningful and push LHDs to make positive changes, while others are meaningless, time consuming and do not result in positive change. This causes staff to feel they are wasting time on "checking boxes," which crowds out time to implement programs and services. Some also mentioned that the number of examples required are excessive and that the annual report is not useful.

> *"…really emphasizing **the cost of doing the busy work**. …some of these other elements that you are required to do, that for your health department have little value beyond the fact it's required for PHAB. That's an expense that I could really live without, **even more so than the cost of the annual fee I could do without in terms of staff time, staff resources,** etc."*
>
> *— Early adopter LHD focus group*

> *"Many of us on this call spent a lot of time and energy trying to answer this section of accreditation about your lab requirement. It was just busy work … because at the end of the day the state provides the lab... But we had to get something [for PHAB] that actually spoke to that directly and **we spent hours trying to chase that down**."*
>
> *— Early adopter LHD focus group*

PHAB performance problems

Some participants mentioned problems with PHAB. They noted three types of performance problems:

- **Slow response times.** Long waits for feedback or next steps from PHAB, particularly during the pandemic. Given that Ohio LHDs receive an increased subsidy once accredited, PHAB delays resulted in funding delays for some LHDs.
- **Site visitor inconsistencies.** Subjectiveness of the site visit process and non-reliable scoring. For example, several participants pointed to instances when two LHDs used the same document and the document was deemed acceptable for one department but not for another.
- **Academic jargon.** Concern that the language in the PHAB standards and measures is too academic and difficult to interpret.

> *"There's no urgency in the PHAB realm, **they are moving at a snail's pace**, [and we] are under the gun to get this done by 2025 [referring to the requirement that LHDs that serve a population of less than 50,000 must either be accredited or conduct* a study evaluating the efficiency and effectiveness of merging with the general health district] *. And I feel very frustrated by that. We had to wait and wait and wait. And you know, it just it doesn't seem very fair."*
>
> *— Not currently accredited LHD focus group [in accreditation process]*

> *"…the difference in the level of scrutiny given by PHAB site visitors can result in some…**unequal or unfair assessment** of one health department versus another. Kind of the easy grader principle, if you will. One is a little easier than the other, so there is a frustration out there and it's understandable."*
>
> *— State government leadership focus group*

> *"[PHAB has] a **very strong academic feel** to those standards. But at the end of the day, they're for local health departments, which are practice-based organizations, so we need those standards to be written for practice-based organizations, not for an academic standard. …thinking through it from a practice standpoint, what does this actually mean?"*
>
> *— Early adopter LHD focus group*

Impact of accreditation on pandemic response

When the COVID-19 pandemic began, ODH and 38 Ohio LHDs were accredited. Many LHDs were in the process of becoming accredited and the pandemic greatly delayed their accreditation timeline.

The focus groups and NORC surveys found some evidence that accreditation strengthened health departments' pandemic response. Some LHDs that were accredited before the pandemic reported that accreditation-related practices increased resilience during the pandemic.

Positive factors attributed to accreditation included the use of social vulnerability index (SVI) data to guide equitable vaccine distribution, improved branding and marketing to raise the visibility of the health department, QI practices to improve vaccine clinics and the usefulness of having standardized documents in a fast-moving situation with high staff turnover.

> *"The learning process, improvement process, and accountability accreditation brought to our agency is extremely valuable for both our agency moving forward and for our community. We did a majority of our improvements to our organization to meet the standards and measures for accreditation between 2016 and 2019. Having those positive changes and improvements in our capabilities across all of the PHAB domains* ***prepared us for success in 2020 and on, especially with responding during the pandemic****."*
>
> *— NORC Post accreditation survey*

> *"I think that the equity work also demonstrates the alignment that accreditation provided between state and LHDs. The state had been providing supports and speaking the common language of accreditation.* ***Providing SVI data as it related to both COVID cases and vaccination rates*** *was an extension of that partnership within the accreditation process."*
>
> *— State government leadership focus group*

> *"[Because of quality improvement projects]* ***our vaccination clinics got a lot better.*** *We had plans that were written down on how we were going to set up our vaccine clinics. Two weeks later, they're completely different."*
>
> *— Accredited later LHD focus group*

Alternatively, some viewed accreditation as having no impact on their LHD's pandemic response. They explained that preparedness efforts from the 2000s, available resources and the political environment had a much larger impact on how a department handled the pandemic than did accreditation.

> *"When you're in the thick of it and you have a stack of cases this tall, and it's 4:15 PM, you've been there since 7:00 AM calling people and getting cussed out,* ***accreditation doesn't do anything for you****."*
>
> *— Accredited later LHD focus group*

> *"**I don't think there was much difference** between accredited and non-accredited [departments in COVID response]. We have a couple just south of us who are not accredited. The difference is in how your communities respond to your recommendations. And based on the political environment and the people around them telling them how to treat you more than what the seal of approval says from the PHAB board."*
>
> *— Accredited later LHD focus group*

> *"We communicated clearly [during the pandemic]… **We did that without accreditation**. I don't know how accreditation would have changed that to be honest, because that's just what you're supposed to do to be a good public health partner."*
>
> *— Not currently accredited LHD focus group*

> *"Many agency improvements were made to achieve accreditation, but they **couldn't be maintained under the weight of our pandemic responsibilities**. They just hadn't been hardwired or firmly embedded into our culture and practices prior to the pandemic hitting us."*
>
> *— NORC Post accreditation LHD survey*

Impact of accreditation on health outcomes

Improved community health is a long-term outcome in the PHAB logic model. However, Ohio public health stakeholders struggled to identify any evidence of accreditation positively impacting population health outcomes.

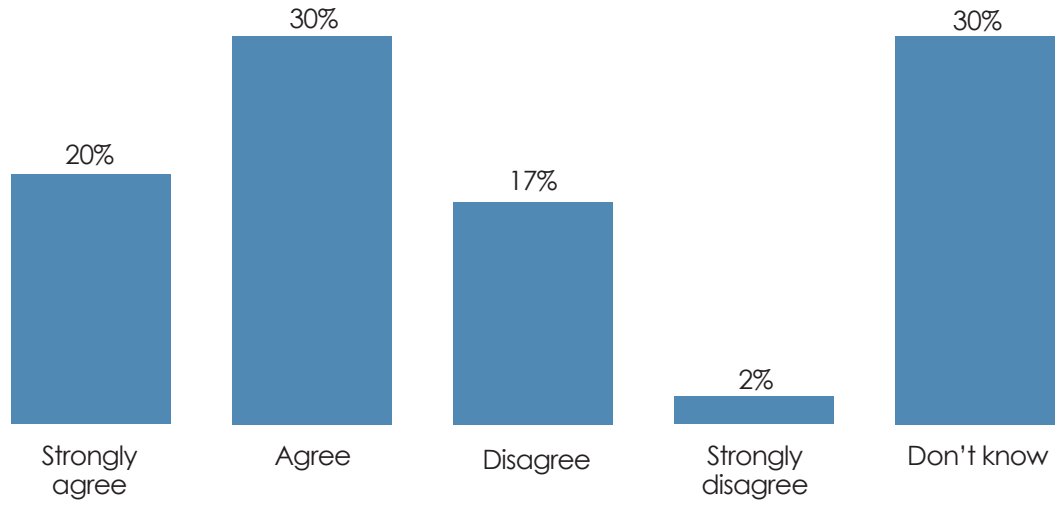
Some focus group participants were hopeful that accreditation would eventually lead to community health improvements but acknowledged that more time is needed and that many factors beyond the scope of public health system performance affect outcomes.

> *"…**it's a little early to be able to evaluate the true benefits**. I would hope eventually that health outcomes is part of that measurement at some point. Yeah, but I think it'd be too early."*
>
> *— Accredited later LHD focus group*

> *"I think, hopefully we will see the proof in the pudding in terms of health, better health outcomes. But again, **accreditation may only be one variable or one factor in that, there's so many other conditions and drivers of health.**"*
>
> *— State government leadership focus group*

As highlighted in figure 4.11, while 50% of NORC survey respondents either agreed or strongly agreed that health department activities implemented as a result of being accredited have led to improved health outcomes in their community,19% either disagreed or strongly disagreed. Another 30% were unsure.

Figure 4.11. **Health department activities implemented as a result of being accredited have led to improved health outcomes in our community** (n=46)



Source: NORC post accreditation survey

While LHD staff struggled to attribute improved health outcomes to accreditation, the accreditation process made LHDs more outcomes driven.

> *"Accreditation has changed the functioning of our agency to be **more focused on outcomes and measurable results** as opposed to running programs without knowing their impact. This keeps us mission focused and better directs appropriate use of limited resources."*
>
> *— NORC Accredited LHD survey*

Group differences in perceived impact of accreditation

Focus group participants with a state-level perspective were the most enthusiastic about the positive effects of accreditation. The state-level leadership group talked extensively about the benefits of accreditation, such as standardization, consistency across departments, performance management and SHA/SHIP/CHA/CHIP coordination. They were optimistic about the ways that widespread accreditation could lead to increased parity in public health capacity and quality across the state and more effective cross-sector population health planning.

LHD representatives had a more mixed view of the overall impact. On balance, many saw the accreditation process as a net positive for their health departments. These participants often talked about how standardization, QI practices and more professional communications have "raised the bar" on the efficiency and effectiveness of their work. However, LHD staff expressed deep frustration about busy work and resource challenges, including cost, for smaller health departments.

Regardless of accreditation timing and status, there was little difference in perceived impact between the three LHD groups, with most describing the impact of accreditation as positive or mixed. Early adopters demonstrated a nuanced understanding of the many costs and benefits of accreditation. All non-accredited LHD participants were in the accreditation pipeline and identified a mix of positive and negative effects of the accreditation process.

PART 5 SYSTEMS CHANGE

How has the public health system, as a whole, transformed as a growing proportion of local health departments in the state have achieved accreditation?

This section focuses on the broader public health system that includes partners beyond governmental public health. State and local stakeholders described the State Health Assessment (SHA)/State Health Improvement Plan (SHIP) and community health assessments (CHAs)/ community health improvement plans (CHIPs) as critical components of a collaborative approach to improving population health. NORC survey findings were consistent with focus group participant perspectives on the impact of accreditation on community partnerships, with some stakeholders describing a positive impact, while others asserted that accreditation has had no impact on partnerships — or has been a barrier to collaboration.

Focus group participants pointed to ways that accreditation has contributed to promising changes in the broader system of organizations that contribute to public health. Perspectives on these changes were much more positive from state-level policy leaders compared to LHD representatives, who described mixed and nuanced views of systems changes. The state-level leadership group focused on ways that accreditation strengthened coordination and alignment, while locals noted some unintended consequences of accreditation on partner relationships and emphasized collaboration that existed prior to accreditation.

State-local alignment through the SHA/SHIP and CHA/CHIP

The SHA/SHIP and CHA/CHIP requirements were seen as a valuable tool to drive coordinated, cross-sector efforts to improve population health and equity. Some focus group participants asserted that many LHDs were already doing CHAs and CHIPs without the PHAB requirement; others noted that accreditation has pushed many LHDs to complete CHAs and CHIPs or to strengthen the quality or comprehensiveness of their CHAs and CHIPs.

Participants in the state leadership group described a clear vision for how the 2016 and 2019 SHAs and the 2017-2019 and 2020-2022 SHIPs and CHAs/CHIPs were intended to align state and local efforts to move the needle on population health outcomes, including:

- A two-way relationship between CHA/CHIPs and the SHA/SHIP where local priorities help to inform state priorities, and state priorities provide guidance to state and local partners
- SHIP priorities and metrics driving alignment and coordination among state agencies, including agencies that directly address the social determinants of health
- SHIP priorities and metrics guiding resource allocation, such as spending by the Ohio Department of Medicaid and other agencies beyond ODH

> *"…there's a CHA CHIP that pushes down, but there's a SHA SHIP that pushes up. And I think there's a concept here of public health being the priority at a state level that is then pushed down through all of the state agencies….[**SHIP priorities] should not just be the responsibility of the Department of Health, that should be the responsibility of all the health and human services agencies**. [Ensure that public health has] money. Medicaid has the money…"*
>
> *— State government leadership focus group*

> *"…the thing I notice the most is that when I'm in partner meetings that are other state agencies…, **people referenced the SHIP**. I think we have at least made significant steps toward that being the case." [ODH staff person]*
>
> *— State government leadership focus group*

> *"…if we cannot address the social determinants, we can't win the health game. The health department in and of themselves can't win the health game. …And **so much of what you see in the SHIP and in the CHIPs can't just be addressed by a health department in and of themselves**, and so I think that's the opportunity for success. I think that the [CHA/CHIP and SHA/SHIP] process has started to cultivate that collaboration, but it's massive."*
>
> *— State government leadership focus group*

Most participants were hopeful that the SHA/SHIP and widespread use of CHAs/CHIPs around the state would lay a critical foundation for systems collaboration. They cited pandemic disruptions, the complex landscape of collaborative relationships and lack of resources as barriers to achieving the vision.

> *"Is it Shangri-La and where probably everybody looks at as a dream state [of state agency alignment]? I would say no, but I think **there's certainly will and lots of effort and real work happening that is coordinated because of that initial effort for the SHA and the SHIP**."*
>
> *— State government leadership focus group*

Local collaboration with hospitals through the CHA/CHIP and CHNA/IS

Focus group participants frequently mentioned hospitals as cross-sector partners and many comments focused on hospital collaboration on CHAs, CHIPs, community health needs assessments (CHNAs) and CHNA-Implementation Strategies (ISs). Many appreciated the goal of better coordination between LHDs and hospitals, but described the reality of complex local planning environments that vary widely from community to community. Focus group participants mentioned several barriers to effective LHD-hospital collaboration on assessments and improvement plans:

- Different assessment and planning timelines
- Requirement to align LHDs and hospitals on a common three-year cycle disrupted by the pandemic
- Lack of pre-existing, cooperative relationships between leaders
- Competition between hospitals
- Large health systems with several hospital facilities
- Lack of requirements for hospital community benefit spending to be allocated toward CHIP priorities
- Vagueness and flexibility of IRS requirements allow for minimal collaboration with LHDs

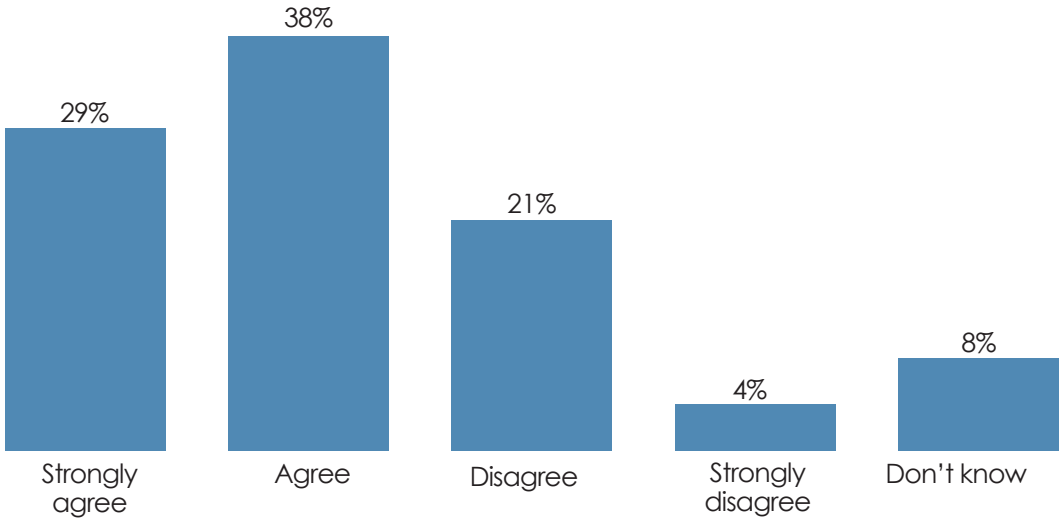
> *"One of the things that came from accreditation was the requirement for us to align our planning with hospitals. Now that was something that had this great concept, I think, behind it and it was really to harness hospitals using money to help. Like **we have all the community connections and the hospitals have the money**. To kind of bring those two together to have more meaningful assessments being done in our communities. But, …that really hasn't been as realized as I think everybody kind of thought it could be and it's kind of falling off the radar. …"*
>
> *— Statewide public health associations and universities focus group*

> *"The truth is the hospitals are more focused on their payer base, their money generators, and meeting* ***the IRS requirement to check the box to be nonprofit****. It's just a different philosophy."*
>
> *— Statewide public health associations and universities focus group*

Other local partner relationships

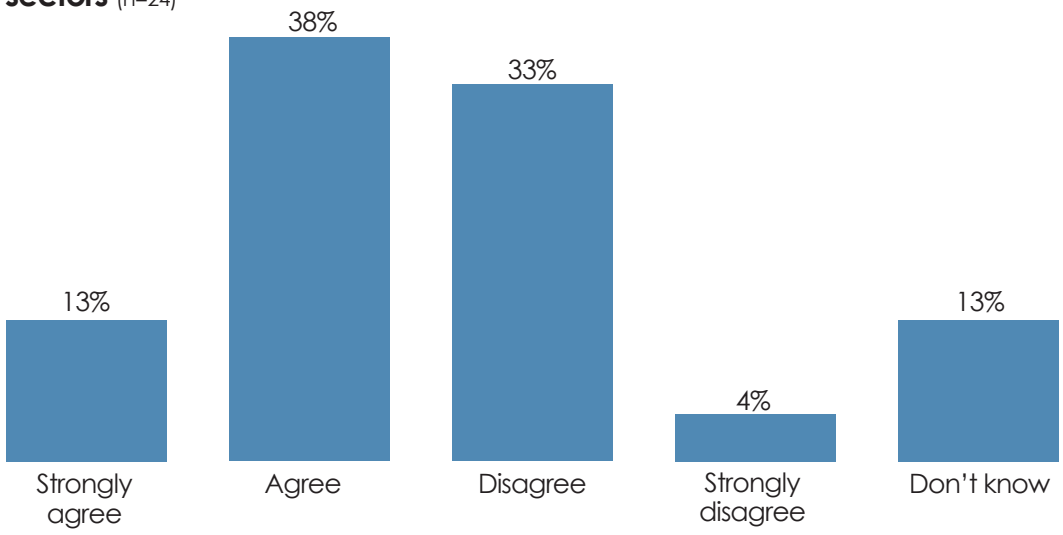
Focus group participants expressed mixed views about the impact of the accreditation process on other partner relationships. Among NORC survey respondents, 67% strongly agreed or agreed that since becoming accredited, their LHD has strengthened its relationship with key partners in other sectors (displayed in figure 5.1). Figure 5.2 shows that 51% strongly agreed or agreed that accreditation has helped them to build relationships with new partners across sectors.

Figure 5.1. **Since becoming accredited, our health department has strengthened its relationship with key partners in other sectors** (n=24)



Source: NORC Survey 4

Figure 5.2. **Accreditation has helped us to build relationships with new partners across sectors** (n=24)



Source: NORC Survey 4

Positive impact. Several focus group participants mentioned that the PHAB standards and measures emphasize collaboration, leading to stronger community partnerships. Some also reported that accreditation has improved their credibility with partners.

> *"[Now] we have quarterly meetings with all four health departments and just about everyone in our community, entire county that's related to health in any way-- mental health, physical health, you name it. And **it has really broadened our horizon, our partner base**. And to me that is probably the biggest positive of accreditation."*
>
> *— Accredited later LHD focus group*

> *"And I do think that it did help us to become better. It helps us to understand our public a little better. And it did help us create **much stronger relationships with our community partners**."*
>
> *— Not currently accredited LHD focus group [in accreditation process]*

No impact. Many participants emphasized that they already had strong community partnerships in place prior to the accreditation process and that accreditation, therefore, had no impact on partner relationships.

> *"I feel like we've had a pretty good relationship with our partners, and **we had a pretty good relationship before accreditation,** and it's really not changed."*
>
> *— Accredited later LHD focus group*

Negative impact. Some participants said accreditation requirements have resulted in unintended consequences, including worsened relationships with community partners. They observed that the onerous nature of some documentation or other requirements (sign-in sheets, meeting minute format, customer surveys, etc.) has made collaboration more difficult, particularly when a coalition is led by another entity.

> *"It kind of **muddied the waters** a little bit. Instead of working together in the way that we have for decades now, we have to look at it as 'hey, public health has to check off this box' and then we'll get back to the work that we were already doing."*
>
> *— Accredited later LHD focus group*

> *"We've had these relationships in these committees that we've been on and **it almost feels as though sometimes we have to hijack the mission of the committee to make it fit into a PHAB box.** …We've got to now do a survey. We've got to tally that survey. We've got to change the way we're going to do things next year because PHAB says we have to."*
>
> *— Not currently accredited LHD focus group [in accreditation process]*

Collaboration during the COVID-19 pandemic. The timing of the COVID-19 pandemic makes it difficult to disentangle the impact of the accreditation process on collaboration. Many LHDs began the initial accreditation process during the pandemic and reported increased community collaboration during that time — partly due to the necessity for a coordinated pandemic response and partly due to accreditation requirements. Hospitals and pharmacies were noted as particularly important partners during this time.

Visibility and credibility of public health agencies among other sectors

A few participants mentioned that accreditation increased the visibility and credibility of public health. They argued that achieving accreditation was seen as a "seal of approval" to other organizations.

> *"I think the biggest thing that accreditation will do for us is kind of put **that stamp on that we are a professional organization** you know and part of something bigger and that we kind of know… what the hell we're doing here. …Like we're in this for a reason. And this accreditation is going to show you that we know what we've been telling you all along that we know what we're doing."*
>
> *— Not currently accredited LHD focus group [in accreditation process]*

Strategic thinking on population health

A few participants also mentioned that accreditation has led their LHDs to think more strategically about population health. This is partly due to a broader understanding of community need and cross-sector issues because of the CHA and CHIP and to PHAB's focus on outcomes and evidence. One commissioner shared that because of the accreditation process, they created a Community Health Planner position whose role is to think beyond specific programs or services and prioritize population health initiatives that involve other partners.

> *"Now [as a result of the accreditation process], I see us really focused much more at a population level and much more to planning and a **strategic level.**"*
>
> *— Statewide public health associations and universities focus group*

PART 6 EQUITY CONTEXT

How do cultural context and historical and structural factors affect participation in the accreditation process?

Focus group participants identified structural, cultural and historical factors that have affected accreditation across LHDs in Ohio, such as inequities in per capita funding and staffing levels, as well as differences in organizational culture and leadership.

Structural factors

Focus group participants emphasized funding differences as a structural factor affecting LHD participation in the accreditation process. LHDs with larger population sizes usually have more resources than those serving smaller communities, although per capita funding can vary widely depending on the presence of public health levies or other local revenue sources. Adequate funding to support staffing, such as an accreditation coordinator, is critical for the accreditation process. Inequities in resources for workforce among LHDs therefore emerged as an important dynamic shaping disparities in accreditation status across the state.

> *"Some cities and counties have levies that support their local health departments so some of the tax dollars go directly to them, others don't. I think for many of them, accreditation required additional resources. …Because we know that not everyone is equal, and **some need more help than others**."*
>
> *— State government leadership focus group*

Cultural context and historical factors

Participants also discussed cultural and historical factors that have affected the willingness of LHDs to seek accreditation. A few LHD representatives mentioned the importance of board support for accreditation and having an organizational culture that values innovation and improvement. They also emphasized the importance of leadership. Health commissioners who value accreditation were eager to lead their departments to successfully pursue accreditation.

However, participants also recounted examples of commissioners who have resisted accreditation because they do not value it or resent the mandate — a history of challenging relationships between LHDs, ODH and the legislature have contributed to strong reluctance to enter the PHAB process for some local leaders. Notably, some stakeholders reported that the state-local relationship has improved in recent years.

> *"I think with anything you have early adopters. You have people who are just maybe naturally inclined, or maybe had a background in quality improvement. …I think a lot of it was **personality-driven** at the beginning."*
>
> *— Statewide public health associations and universities focus group*

> *"And then you have folks who **just don't like being told what to do** by the legislature or the state."*
>
> *— Statewide public health associations and universities focus group*

PART 7 EQUITY IMPACT

? In what ways are accreditation and the accreditation requirement likely to affect equitable distribution of public health resources across the state and disparities in health outcomes?

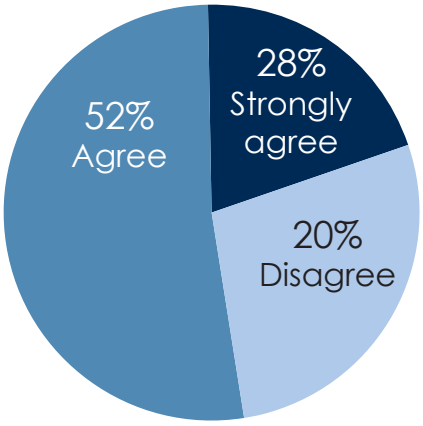
NORC survey results indicate that many—but not all—local health departments (LHDs) were prompted to enact a stronger focus on health equity because of the accreditation process. Focus group comments provide context for why some LHDs are frustrated by the Public Health Accreditation Board's (PHAB's) equity requirements—often mentioning a perception that rural communities cannot correctly "check the box" on equity due to lack of racial diversity.

State leaders emphasized that the purpose of the mandate was to increase equitable distribution of public health resources across the state. Most focus group participants agreed that this has not yet happened and that it is too soon to expect an impact on health disparities in the state as a result of accreditation.

Impact on LHD activities

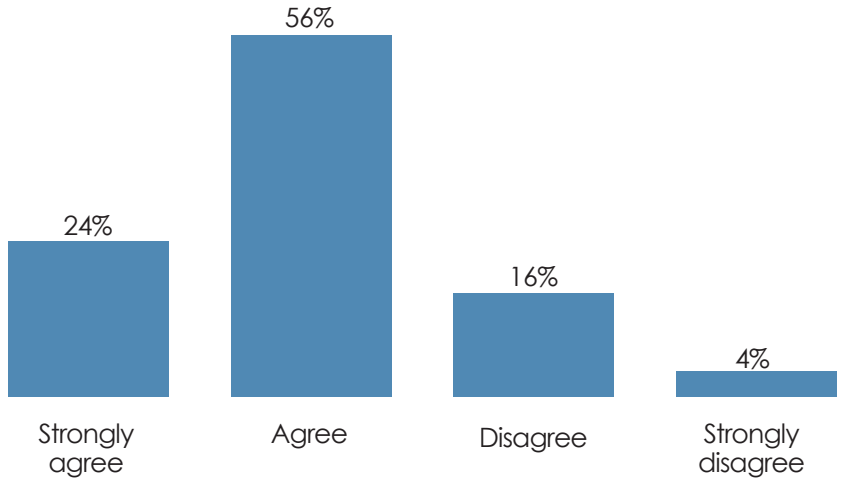
Several LHDs reported that the accreditation process has helped them strengthen their approach to equity. For example, 80% of NORC survey respondents agreed or strongly agreed that their department has applied health equity to internal planning, policies or processes as a result of accreditation (survey results displayed in figure 7.1). Figure 7.2 demonstrates that 80% of NORC survey respondents strongly agreed or agreed that accreditation has helped their health department use health equity as a lens for identifying and addressing health priorities.

Figure 7.1. **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

Figure 7.2. **Accreditation has helped our health department use health equity as a lens for identifying and addressing health priorities** (n=25)



Source: NORC post accreditation survey

Challenges with addressing health equity

In response to questions about equity, focus group participants often expressed frustration about difficulty meeting PHAB's equity standards. LHD representatives serving predominantly white communities often perceive that racial equity is "the only thing that counts for PHAB." Some talked about having difficulty producing documentation to meet equity standards, or that their CHA/CHIP had been critiqued by PHAB for not having enough of an explicit focus on disparities or racial equity. A few also mentioned that the political climates in their communities sometimes make it difficult to address topics such as harm reduction, immigration, and racial equity.

> *"**Equity as dictated** in the standards is problematic."*
> *— Early adopter LHD focus group*

> *"We are an Appalachian health department, so we are going to rely heavily on, not necessarily maybe color, but as far as serving our rural Appalachian population as our means of diversity. And **if that's not good enough for PHAB**, that could be a big problem for us."*
> *— Not currently accredited LHD focus group*

Impact on equitable distribution of resources

Participants in the state policymaker group were the only stakeholders who commented on how the accreditation requirement could increase equitable distribution of resources among health departments. They noted that one of the goals was to ensure consistent quality and capacity among LHDs across the state.

> *"From the administration standpoint, it was a real opportunity just to make sure wherever you were in the state, **you knew your public health district had enough capacity to be able to get the job done**."*
> *— State government leadership focus group*

> *"I think accreditation really homes in now on equity and it will ensure equity because **you're going to get similar services and similar resources from your health department no matter where you live in Ohio**."*
> *— State government leadership focus group*

Impact on disparities in health outcomes

Participants generally said that it is too soon to expect that accreditation impacted health disparities. However, some asserted that the PHAB standards and measures had prompted their LHD to have a more intentional approach to equity, which may yield positive outcomes in the long term. They pointed specifically to increased use of Social Vulnerability Index (SVI) data, improved community engagement and a stronger focus on evidence, outcomes and social determinants of health.

> *"There was **a requirement to show that our health department can conduct activities off site and still remain accessible** to people with physical disabilities or people with language limitations. So that's when I started to tell the nurses… 'hey, you need to be taking the interpreter's phone number, the interpreting service phone number with you. So if you do get a patient who's not English proficient, then you need to call and get an interpreter'"*
>
> *— Accredited later LHD focus group*

Several participants in the LHD focus groups raised concerns about barriers to addressing equity. For example, one commissioner argued that the opportunity cost of staff time spent on accreditation documentation results in fewer resources to devote to programs and services that could reduce disparities.

> *"I could just as easily say take **all the money you're spending to check boxes** and start working on health equity in your community and probably have the same outcome."*
>
> *— Early adopter LHD focus group*

Other barriers included political climates that make it difficult to serve populations such as immigrants or members of the LGBTQ+ community, and perceptions among some rural LHDs that they cannot adequately meet PHAB equity standards because their populations are predominantly white.

> *"I suggested to my Health Commissioner today, you know, 'here are some priorities we need to think about,' and I listed some things such as addiction, and services for people who are LGBT, immigrants. My boss said yes, these are valid points and he is very supportive. But he said **we'll also [need to] be aware that these are very political issues**."*
>
> *— Early adopter LHD focus group*

PART 8 SOCIAL RETURN ON INVESTMENT

What inputs, outputs and outcomes should be measured in order to assess the Social Return on Investment (SROI) of accreditation of local health departments?

This study approached the costs and benefits of PHAB accreditation using the Social Return on Investment (SROI) framework, which analyzes inputs, outputs and outcomes to determine the total social value of a program. This section describes the focus group and NORC survey findings relevant to costs and benefits. Appendix B includes additional detail about the SROI framework and provides an outcome map for future data collection and analysis.

Focus group participants and NORC survey respondents identified many accreditation-related costs beyond the PHAB fees, emphasizing staff time and opportunity costs. While many benefits of accreditation were noted (as described in Part 4), focus group participants and NORC survey respondents expressed mixed views on the overall value of accreditation and were cautious about ascribing improvements in population health outcomes to accreditation.

Inputs: Costs

Within the SROI analysis, inputs refer to the resources needed to secure accreditation. The vast majority of resources to support local health department (LHD) accreditation come from the LHDs themselves. In Ohio, local revenue sources (e.g., local general revenue, levy funds, fees and healthcare reimbursement) make up the largest portion of LHD funding.

Focus group participants mentioned several direct and indirect costs of accreditation to health departments, including:

- PHAB application and annual fees
- Pre-requisite activities (community health assessment (CHA), community health improvement plan (CHIP) and Strategic Plan), including the costs of collecting or purchasing data for the CHA, as well as for hiring consultants (if needed or feasible)
- Salary and benefits for the accreditation coordinator and/or accreditation consultant(s)
- Staff time to create and compile documents and policies, participate in accreditation-related trainings and meetings (mileage and hotel costs, in some cases) and other accreditation-related activities
- Lost revenue and opportunity costs due to staff spending time on accreditation tasks rather than fee-generating direct services and other services and programs

Many focus group participants emphasized the staff time needed to achieve accreditation, arguing that the cost of this staff time exceeds the cost of the PHAB fees and that some documentation paperwork is not valuable to the LHD.

> *"[PHAB] fees seem like a drop in the bucket compared to **staff time on the busy work**."*
>
> *— Early adopter LHD focus group*

> *"Well, I'll say that one of the negative things is definitely the amount of staff it took. …**it took a lot of people off the regular jobs, and it took people out of the public**. [The accreditation process took us] out of the public and onto the paperwork at your desk."*
>
> *— Later adopter LHD focus group*

LHD representatives were also concerned about the ways that accreditation-related work crowds out other programs and services.

> *"I'll put it this way, we're going to have a whole lot of accredited health departments that don't have any programs left because **they're spending all their general funds getting accredited**. And that's a dramatic example. But to some degree, I think there's truth in there."*
>
> *— Statewide public health associations and universities focus group*

> *"For example, we got our enforcement and building department to start helping us with nuisance complaints simply because **we couldn't keep up** going through the accreditation process."*
>
> *— Later adopter LHD focus group*

Inputs: Policy context of costs

Ohio's accreditation requirement is a significant policy input. While participants in the state-level leadership focus group expressed positive views about the mandate, most participants in other groups had more mixed or negative opinions of the state's requirements (see Part 9 for more detail).

Uneven funding and capacity among LHDs was frequently mentioned as a cost challenge, with representatives of smaller LHDs often expressing frustration that they were being "forced" to do accreditation and must produce the same amount of documentation as larger LHDs. Given their smaller staff sizes, they said the costs of accreditation — particularly the staff time required — are disproportionately high for LHDs with fewer resources.

> *"…when most of us are levy funded and we use those levy dollars to stretch as far as we can and even the state subsidy that we got from ODH barely covered our annual fee. And that's just the annual fee, not the application fee. So it has a huge impact financially and then for Ohio to mandate it. **Health departments have no choice, so you have to pay that every single year, whether you have a levy or a state subsidy."***
>
> *— Accredited later LHD focus group*

> *"Also, it's really freaking expensive. We're a city health department. We don't have a levy, we don't have anything. …You know our taxpayers, **our city taxpayers are paying for that and accreditation is a large line item** for us on top of having to fund a CHIP and a CHA, very little is left over to actually do the programs that, you know, [are] required or, you know, funded. …**We have to pay for something that says we're doing a good job. But we can't fund the programs fully the way that we should be funding** and I don't like that."*
>
> *— Not currently accredited LHD focus group [in the accreditation process*

One participant mentioned a more recent state policy change regarding Ohio Department of Health (ODH) grant reporting that will affect the amount of resources LHDs have to allocate towards staff time for accreditation tasks. In May 2022, ODH issued a memo stating that their grant reporting would no longer be solely deliverables based, but would also require reporting on staff time and effort.[9] One unintended consequence of this change may be a reduction in flexible staff time that can be spent on accreditation activities.

> *"…So it used to be that a staff person could spend some of their time doing accreditation related things and some of their time doing something for a grant from ODH. And because it was just deliverables based, ODH couldn't see that, everything was fine, everybody went on their merry way. Now, you have to show that. **So that time spent on accreditation is not allowed [to be covered by ODH grant funds]?"***
>
> *— Statewide public health associations and universities focus group*

Inputs: Accreditation supports

Focus group participants mentioned that the following inputs have been helpful in supporting the accreditation process:

- Funding from or through ODH, such as an increase to the state subsidy for accredited LHDs; specific funding opportunities for accreditation learning communities and mergers; and funds from the federal Public Health Infrastructure Grant, which can be used for workforce
- Technical assistance and learning communities facilitated by the Ohio Public Health Partnership (OPHP) and Association of Ohio Health Commissioners (AOHC)
- Peer-to-peer sharing facilitated by increased standardization across LHDs as a result of accreditation
- Clear Impact platform provided to LHDs (funded by ODH) for tracking and reporting performance management
- LHD leadership that is supportive of the purpose and value of accreditation

Focus group participants expressed gratitude for funding from ODH that have supported accreditation over the past decade, as well as long-standing technical assistance provided primarily through OPHP. They also described an active network of peer-to-peer sharing among LHDs where those who have successfully achieved accreditation (or reaccreditation) provide examples and guidance to those going through the process.

> *"I think that the ALC [Accreditation Learning Community] is good. …The director [of OPHP] will even tell them, like, 'hey, call Clermont County.' Like* ***we will get emails from different people on different measures where they think we've done well on something.****"*
>
> *— Early adopter LHD focus group*

> *"… because we shared and we borrowed, things might look similar. You had to develop it for your own, but* ***I think we're more standardized across the board because we've shared and we've all gotten to 'this is the best way to do it.'****"*
>
> *— Statewide public health associations and universities focus group*

Outputs

Within the SROI analysis, outputs refer to benefits that accreditation concretely provides to health departments. These are described in detail in part 4. In summary, the main benefits identified in the focus group and NORC survey findings were:

- Specific public health capabilities, particularly:
  - Performance management, quality improvement and evaluation
  - Collaboration and partner relationships
  - Communications
- Standardization and efficiency within departments
- Increased state subsidy
- Capacity for optimal future investments in LHDs
- Organizational preparation
- Staff pride

Outcomes

Within the SROI analysis, outcomes refer to the social goods generated by accreditation. Focus group participants struggled to identify any evidence of accreditation currently having a positive impact on population health outcomes. As described in part 4, some were hopeful that accreditation would eventually lead to community health improvements, but they acknowledged that more time is needed and that many factors beyond the scope of public health system performance affect outcomes.

Costs vs. benefits

Overall, focus group participants and NORC survey respondents expressed mixed views about the return on investment of accreditation. While many could point to improvements to ODH and LHDs because of the accreditation process, most LHD representatives emphasized the high costs of fees and staff time:

> *"…from my personal experience, **I have a very positive ROI**."*
> *— Statewide public health associations and universities focus group*

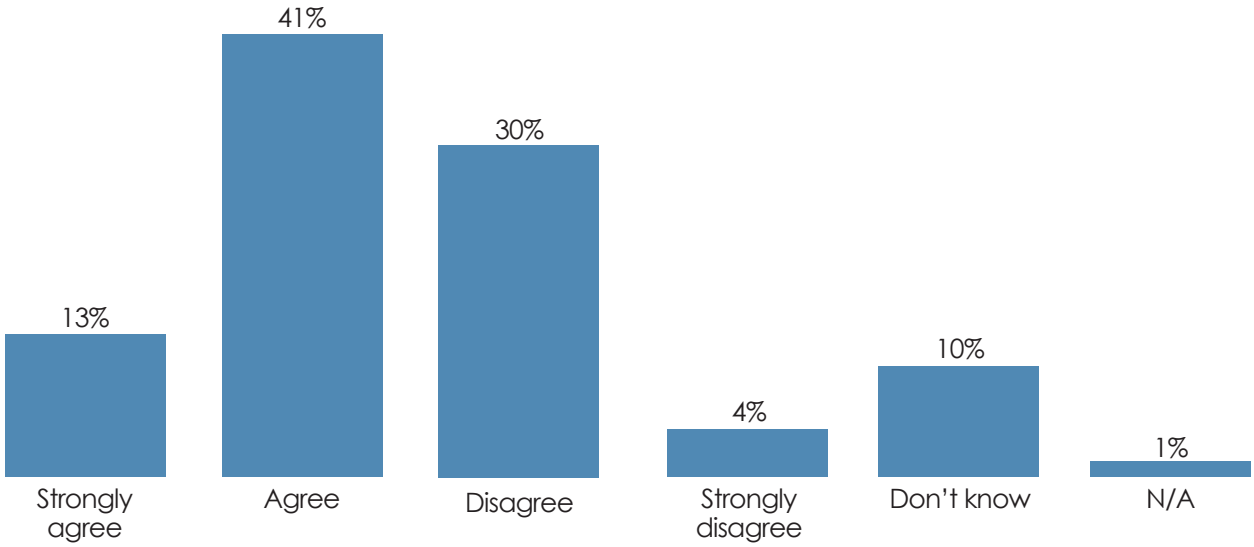
> *"Just a lot of resources, personnel and financial, and it's just a lot. Do I value PHAB? Yes, I do. I do. I value it. **I don't know if I value it at the level that it's costing me.** I can't say to you that I value it at that level. I can see the benefit of it. I have not seen the outcomes in health that have been promised by being an accredited health department, but you know, I remain hopeful, but it is a little frustrating."*
> *— Not currently accredited LHD focus group [in the accreditation process]*

> *"I think the more the locals have gotten accredited themselves or gone through the process, I think the more and more have seen the benefits of it, but **still are challenged with the price tag..."***
> *— Statewide public health associations and universities focus group*

> *"At this time knowing we have achieved the PHAB standards and measures, it has cost our agency significant funds to prepare and also annual costs to PHAB with **minimal financial incentive or benefits**."*
> *— NORC Post Accreditation Survey*

As shown in figure 8.1, NORC survey respondents were split on whether PHAB accreditation fees are a "good value." About half (54%) agreed or strongly agreed that they were, while 45% disagreed or strongly disagreed or said they did not know.

Figure 8.1. **Health department leadership team views the PHAB accreditation fees as a good value** (n=69)



Source: NORC accredited survey

PART 9 LESSONS LEARNED

? What lessons can be learned from the Ohio experience that could be applied to other states considering strategies to incentivize accreditation within the state?

Focus group participants provided suggestions for other states working to increase accreditation. This section summarizes lessons learned that were frequently discussed during the focus groups, with emphasis on concepts applicable to other states or to PHAB that have not been fully explored earlier in this report.

Lesson 1 State and local policymakers have different perspectives on actions taken to require accreditation. Trust, clarity of purpose and funding are key to making a mandate effective.

State policymakers expressed a mostly positive view of the accreditation mandate. They emphasized the value of increasing consistency across local health departments (LHDs) and pointed to the large number of LHDs in Ohio that have achieved accreditation. LHD representatives were more likely to have a negative or mixed response to the mandate. Concerns about state policymaker intent and lack of resources, in the context of a local control state, have fueled skepticism and delayed some LHDs' entry into the accreditation process.

Trust between state and local stakeholders matters. Tensions between LHDs, the Ohio Department of Health (ODH) and the General Assembly existed in Ohio long before PHAB implementation. These tensions have affected the level of trust between state and local stakeholders, and therefore shaped perceptions of state policy actions requiring accreditation. Some LHD representatives in the focus groups described what they saw as state leaders' "hidden agenda" to use the accreditation mandate to force mergers among LHDs serving population sizes under 50,000. State leaders, on the other hand, described a vision of accreditation leading to consistent capacity and quality of public health services across the state. They acknowledged that in some cases this could require consolidation of departments to ensure that all Ohioans have access to the foundational public health services (FPHS).

> *"The idea was through accreditation you could **identify a capacity to actually get the job done**. So it wasn't explicitly a consolidation strategy, but I think it was pretty clear that some small units might have a hard time achieving accreditation. The idea was there are opportunities to kind of show resources in a way to get to a level of capacity that would let you get the job done."*
>
> *— State government leadership focus group*

> *"After 27, 28 years in public health, I've been around long enough to see where the origins of this mandate came into place by our legislature and by the Governor at that time. The mandate in Ohio was never about quality improvement, although it's a great sound bite. **It was really a backhanded way to force consolidation and regionalization**."*
>
> *— Later adopters LHD focus group*

> *"The other thing is intent. You have to have a genuine intent if you want this to happen. … I think everybody understood **there was another agenda behind it**. So, it has to be genuine. One way to make it genuine is to include yourself [ODH] in the mandate."*
>
> *— Statewide public health associations and universities focus group*

Jurisdiction population size is an unresolved issue. All LHDs, regardless of jurisdiction size, must meet the same PHAB standards and measures and submit the same number of documents. For many state policymakers, this is a way to ensure consistency across LHDs and adequate FPHS in rural areas. For most small LHDs, however, it is seen as an unfair burden that overtaxes their limited resources and reduces staff time available to provide valuable services. Ohio does not recognize completing PHAB's **Pathways Recognition Program** as sufficient and some focus group participants expressed frustration about full accreditation as a "one size fits all" approach that does not fit them.

> *"So, I do think there's an ideal size for a health department. I know we never wanted to force certain regions together or force people to join. But I do think **we need to do something about setting a level of funding and expectations of service** to build upon what PHAB is accomplishing."*
>
> *— State government leadership focus group*

> *"[Accreditation is] just a heavy lift for such a small organization. And I'm fully promoting accreditation. I appreciate that process, but just think that **Pathways would be much more helpful at least for those Ohio counties that are smaller**. So rather than that mandate for that national accreditation, if there was a step in between, to allow that Pathway program to be in place, [it] would be helpful."*
>
> *— Later adopter LHD focus group*

Mandates drive resistance. Focus group participants described strong resistance to the accreditation mandate among some of their LHD colleagues. Because Ohio is a decentralized, local control state with minimal state funding for LHDs, state requirements are often viewed as an unfair imposition on local resources. Participants from non-accredited LHDs generally reported an openness to accreditation but were frustrated by the high cost and some felt they needed more time to comply.

> *"It's kind of that **home rule mentality**. You can't tell me what to do."*
>
> *— Statewide public health associations and universities focus group*

> *"I think if it were approached a little bit differently and more like a **'come along with me' rather than dragging**, it could have been a lot less bumpy. If other states are going to learn from this, that's one key take away. You're never going to get 100% support, no matter what. But I think that would have gone a long way toward smoothing the road to get there."*
>
> *— Statewide public health associations and universities focus group*

> *"**Mandating accreditation does not make better health departments**. …People who chose to do it is because they're embracing that culture and they're actually doing the work around accreditation that makes us better. The ones that went kicking and screaming (like some of my staff do), I know a lot of them, they're going through the process and they're checking the box, but… they don't have the passion for it and they're not actually implementing it in a meaningful way..."*
>
> *— Early adopter LHD focus group*

The vision for increased funding has not been fully realized. Focus group participants frequently mentioned the high costs of accreditation and how the increased state subsidy for accredited LHDs is not sufficient. State policymakers focus group participants described a vision for how widespread accreditation would lead to increased resources for LHDS, such as by helping departments win grants, convincing the legislature to allocate more funding to public health or by leveraging hospital community benefit dollars through coordinated community health assessment (CHA)/community health improvement plan (CHIP)/community health needs assessment (CHNA)/implementation strategy (IS) initiatives. Most focus group participants agreed, however, that this increased funding (as a result of accreditation) has not yet materialized.

> *"We tried and it wasn't successful, but in a dream world there would have been funds behind that accreditation [mandate] … **the General Assembly should have stepped up** on some public health initiatives. They should have given an enhanced reimbursement to accredited districts and that would incentivize the behavior. … but that hasn't happened."*
>
> *— State government leadership focus group*

> *"Consider providing funding for accreditation efforts. But then also in the future if you're accredited, you get rewarded with additional funding to take on new programs or things like that. So, I think other states should try to make [accreditation] a joint goal and a joint effort, from local health departments and the state health department and partners. …But **I don't think you can force it with a stick only**, there's got to be some carrots in there, whether it's funding up-front or funding after you become accredited."*
>
> *— State government leadership focus group*

Lesson 2 The accreditation process is a heavy lift. Significant resources for technical assistance and workforce are needed to make it successful.

Although most focus group participants described accreditation as a net benefit for public health, many also emphasized how challenging and staff-intensive the process is.

Technical assistance is needed and appreciated. Many focus group participants expressed gratitude for technical assistance provided through the Accreditation Learning Community (ALC) and other sources over the past 10 years. They also talked about the importance of peer-to-peer sharing and having centralized repositories for accreditation-related resources, such as templates and local data.

> *"I think if they want to see more states take off with accreditation like Ohio has, then they need to provide **more guidance** on what kind of infrastructure and what kind of foundational supports are helpful for states. It just makes sense for that guidance to come from PHAB."*
>
> *— Statewide public health associations and universities focus group*

A robust workforce is needed to achieve and maintain accreditation. Focus group participants said that having an accreditation coordinator is critical and that many other staff are involved in accreditation-related activities. Some also discussed struggles with recruiting and retaining staff and how staff turnover can delay the accreditation process.

Lesson 3 Future revisions to the PHAB standards and measures could improve the value of accreditation.

There was widespread consensus among focus group participants that the accreditation process has had a mix of positive and negative impacts on health departments and that some PHAB standards are more useful than others. During the discussion with early adopters (many with 10 or more years of accreditation experience), participants agreed that PHAB measures and other accreditation-related activities could be categorized along a continuum of usefulness and impact, as summarized in figure 9.1.

Figure 9.1. **Accreditation impact typology**

Impact of accreditation	Accreditation-related activities
Low impact *Accreditation does not result in meaningful change*	Useful activities the department was already doing and would do regardless of the accreditation process.
High impact *Accreditation results in performance improvements*	Useful activities the department was not doing consistently or effectively prior to accreditation. The accreditation process pushes the department to strengthen performance and become more accountable.
	Useful activities the department was not doing at all prior to accreditation. The accreditation process pushes the department to add new practices or competencies.
Potentially negative impact *Accreditation activities may drain department resources and crowd out more constructive activities*	Activities that are not useful that the department is only doing because PHAB requires them. Activities that lack evidence of impact on improving health department performance, equity or community health outcomes.

Ohio LHDs and other public health stakeholders would benefit greatly from changes to the accreditation process that reduce the administrative burden of activities that have low or potentially harmful impact and focused more strongly on activities with high impact.

Decisions about which PHAB prerequisite activities, standards and measures are high impact should be informed by both research evidence and practice-based evidence from health department staff. Given Ohio's extensive history with accreditation, Ohio stakeholders are well-positioned to inform any future work that assesses the value of specific accreditation-related activities.

PART 10 DISCUSSION

Key findings

The following key findings emerge from analysis and synthesis of the data sources used in this study:

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.
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.

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. In addition, state health departments can lead by example through transparent communication with LHDs about their experiences with accreditation and how they are improving performance as a result of accreditation.

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-impact 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.

Recommendations for Ohio

Administrative burden. ODH should continue to identify ways to reduce reporting requirements and other administrative burdens for accredited LHDs. PHAB accreditation should serve as evidence of adequate performance, rather than a duplication of other state requirements.

Population size and funding. State and local public health stakeholders should work towards consensus on the goal and long-term vision for accreditation and re-accreditation of LHDs serving small population sizes (e.g. <50,000).

- If Ohio's goal is consistent capacity and quality across LHDs, regardless of size, then provide funding, technical assistance and other support to smaller LHDs to ensure they are successful.
- If Ohio's goal is a flexible approach to accreditation that allows for variation in LHD capacity and quality across the state, then reconsider the Pathways program or other alternatives to full accreditation/re-accreditation.
- 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.

Equity technical assistance. ODH and other statewide public health organizations should support training, coaching and peer-to-peer sharing for LHDs to better understand the many ways that they can work towards more equitable communities, including guidance for rural LHDs on activities tailored to engage and meet the needs of people with low incomes and disabilities, veterans, immigrants, etc.

Limitations

Sampling

First, study findings may be affected by voluntary participation bias. Although participants for the focus groups, key informant interviews and SROI discussion group were recruited using either a purposive approach or a stratified random sample approach, it is important to note that participation was voluntary. Individuals who chose to participate may have had strong pre-existing opinions about PHAB accreditation and Ohio's accreditation mandate. As a result, the views expressed in the study may not fully represent the spectrum of opinions within Ohio, potentially introducing bias into the findings. Second, the stratified random sample approach used to recruit LHD focus group participants yielded balanced representation from LHDs by accreditation status and population size (refer to Appendix A). However, focus group participants were not necessarily representative of the geography of all LHDs or of the Ohio population (as displayed in figure 10.1). Relative to the distribution of LHDs in the state, LHDs in metropolitan and Appalachian counties were over-represented in the study. Relative to Ohio's population, LHDs in metropolitan counties were highly under-represented, while LHDs in Appalachian counties were highly over-represented. This is important to keep in mind when interpreting the focus group findings about equity.

Figure 10.1. **LHD focus group participants, Ohio LHDs and Ohio population, by county type**

County type*	LHD focus group participants (n=24)	Ohio LHDs (n=111)	Ohio population (2022)
Metropolitan	27.3%	18.9%	53%
Suburban	13.6%	16.2%	17%
Appalachian	40.9%	36.9%	17%
Rural non-Appalachian	18.2%	27.9%	13%

*Using the Ohio Medicaid Assessment Survey (OMAS) county typology.
Source: Ohio population data is from the U.S. Census Bureau American Community Survey 5-year estimates

Third, sample sizes were relatively small for the NACCHO Profile survey and some of the NORC surveys. The response rate among Ohio LHDs to the 2019 NACCHO Profile Survey was 55% (61 LHDs), including only 10 non-accredited LHDs, making it difficult to compare LHDs by accreditation status. The number of NORC survey respondents ranged from eight to 97 per survey, and the volume of open-ended responses was limited for some questions.

Generalizability to other states

The findings are based on data collected from participants in Ohio, and therefore, the conclusions drawn may not be directly applicable to other states. Each state has its own unique context, policies and public health infrastructure, which can influence the perceptions and experiences related to public health accreditation. Therefore, while the study provides valuable insights specific to Ohio, readers should exercise caution when extrapolating these findings to other settings.

Appendix A METHODOLOGY

Focus groups

HPIO facilitated five focus groups via Zoom in January 2024. A total of 41 public health stakeholders participated. Figure A1 describes the sampling method used for each group. For the local health department (LHD) groups, HPIO invited the health commissioner to participate and gave them the option to delegate another staff member if needed. In most cases, the commissioner participated, although some accreditation coordinators were also present.

HPIO used a semi-structured interview script (unique script for each group to comply with federal regulations). The facilitator obtained verbal consent from each participant to record the discussion (all approved). The facilitator also informed participants that direct quotes would be included in the report, but no comments or opinions would be connected to individual or specific participants. The discussions were transcribed using Microsoft Word transcription and then reviewed by HPIO to reconcile any inconsistencies with staff notes.

HPIO iteratively coded the transcripts, using open and descriptive coding methods. HPIO conducted a thematic analysis, using a hybrid approach with inductive coding, as well as deductive codes based on themes from the PHAB logic model.

Figure A1. **Focus group participants and sampling**

Group	Number of participants	Sampling
State level		**Key stakeholders familiar with accreditation and the public health system**
1. State government leadership	8*	Purposive sample: HPIO developed a sampling frame of current leadership at the Ohio Department of Health (ODH), state leaders involved in the 2013 mandate legislation (executive branch and legislators), statewide public health associations and Ohio universities. HPIO invited key public health advisors to provide input on the list.
2. Representatives of statewide public health associations and universities	9	
Local level (LHDs)		**Local health commissioners or other high-level local health department staff**
3. Early adopters accredited (and/or re-accredited) (2013-2017)	8	Stratified random sample: HPIO constructed a sampling frame from the list of PHAB-accredited LHDs from the PHAB website, as well as a list of current LHDs from ODH. Within each accreditation status group, HPIO stratified the sample by population size (dichotomous >/≤ 50,000), percent Black (dichotomous >/≤ 13%) and county type (urban, suburban, Appalachian, non-Appalachian rural[10]). HPIO used a random number generator to select nine top-priority recruits. When invitees did not respond, HPIO randomly selected an additional LHD within the same stratified group.
4. Accredited later (2018-2023)	7	
5. Not accredited (as of November 2023)	9	

*Includes one state leader who was not able to participate in the focus group interview but completed a one-on-one interview.

Figure A2. **LHD focus group stratification characteristics**

	LHD focus group participants (groups 3-5)	
	Number	Percentage
Jurisdiction population size < 50,000	11	50%
Jurisdiction population size ≥ 50,000	11	50%
Percentage of the population in the county where the LHD is located that is Black: < 13%	18	81.8%
Percentage of the population in the county where the LHD is located that is Black: ≥ 13%	4	18.2%
County type		
Metropolitan	6	27.3%
Suburban	3	13.6%
Appalachian	9	40.9%
Rural non-Appalachian	4	18.2%

21st Century key informant interviews

HPIO interviewed two key informants via Zoom. Using a semi-structured interview script, the interview addressed this research question: How has participation in the 21st Century Learning Community supported health department transformation in Ohio? Audio and video recordings were made of the interviews, which were then transcribed verbatim using Microsoft Word transcription. Analysis of the data began with a qualitative thematic content analysis to identify reoccurring concepts in the interview data. Data extracts were placed under each category depending on their relevance and then analyzed.

NORC surveys

NORC at the University of Chicago conducts surveys across the accreditation process on behalf of PHAB. There are five surveys representing touch points in the accreditation process. Data from Ohio health departments was used for this study. Figure A3 summarizes the survey topics, response numbers and years of survey data. Survey questions were mapped onto the project research questions and analyzed using descriptive statistics.

Figure A3. **NORC surveys**

Survey number	Survey topic	Milestone	Number of Ohio respondents	Response years
1	Applicant survey	Applicant health departments that have registered their intent to apply for initial accreditation, prior to attending the PHAB accreditation training.	97	2013-2021
2	Accredited survey	Health departments shortly after they achieved initial accreditation.	70	2013-2022
3	Post accreditation survey	Accredited health departments approximately one year after the initial accreditation decision.	49	2014-2022
4	Year 4 Accreditation Survey	Accredited health departments approximately four years after the initial accreditation decision, as they approached reaccreditation.	24	2017-2022
5	Reaccreditation survey	Health departments shortly after they achieved reaccreditation.	8	2020-2022

Annual Financial Reports

Data was obtained from Ohio LHDs' Annual Financial Reports (AFRs), which LHDs are required to compile and submit annually to ODH. AFRs contain detailed information on LHD staffing and spending, with a focus on attainment of, and spending on, the Foundational Public Health Services (FPHS). For this report, the research team analyzed data from AFRs for state fiscal years (SFYs) 2021 and 2022 for 98 of Ohio's 111 LHDs (88%). Key variables examined include LHDs' full-time equivalent (FTE) staffing, per capita spending on all public health activities, per capita spending on the FPHS and per capita investment gaps to fully implement the FPHS. Investment gaps were estimated based on LHDs' current level of per capita spending and the level of attainment of each of the foundational services that comprise the FPHS.

NACCHO Profile

Data was obtained from the 2019 NACCHO (National Association of County and City Health Officials) Profile Study, the most recent year for which Profile data was available to external researchers. In 2019, 61 of Ohio's 111 LHDs (55%) completed the NACCHO Profile survey. Key variables examined include LHD completion of community health assessments (CHAs), community health improvement plans (CHIPs), and strategic plans and LHD collaboration with nonprofit hospitals on the latter's federally required community health needs assessment (CHNA).

Social return on investment (SROI) discussion group

HPIO contracted with an economist experienced in social return on investment (SROI) analysis to facilitate a discussion with key public health stakeholders in March 2024. Using snowball sampling, HPIO informed participants in the five focus groups about the SROI session and asked for volunteers and recommendations of stakeholders to invite. Eight participants attended the meeting, including representatives from LHDs, ODH and statewide associations/organizations. Three of the 8 participants also took part in the main focus groups.

HPIO hosted the meeting via Zoom and obtained verbal consent from each participant to record the discussion (all approved). The discussions were transcribed using Microsoft Word transcription and then reviewed by a team member to reconcile any inconsistencies with staff notes.

Appendix B ESTIMATING SOCIAL RETURN ON INVESTMENT FOR PHAB

The following memo was prepared by Scioto Analysis for HPIO as a deliverable for this project.

Executive summary

Social return on investment analysis is a framework for measuring and accounting for the total social value of a program. Understanding the costs and benefits of accreditation is an important aspect of evaluating accreditation for public health departments. To inform the current analysis of accreditation, the PHAB research team mapped outcomes related to social return on investment of accreditation. This analysis sheds light on the inputs, outputs, and outcomes associated with accreditation and the potential social value generated through these outcomes.

Inputs identified included **PHAB application and annual fees, prerequisite activities, salary and benefits, staff time and lost revenue**. These inputs can cost upward of half a million dollars for a public health department. Outputs of particular value mentioned in focus and discussion groups were **performance management, quality improvement and evaluation, collaboration and partner relationships, and communications**. Participants said outcomes were difficult to measure in the short- and medium-term.

Future work for PHAB could be to conduct a comprehensive social return on investment analysis.

Background

Since the state of Ohio mandated local health departments in the state be accredited in 2013, Ohio has been a testing ground for accreditation of public health departments. With this evaluation of the accreditation mandate in Ohio, PHAB seeks to understand how this experiment has played out. Understanding the costs and benefits for the state, public, and local health departments is a valuable component of understanding the impact of accreditation within the state.

Logic model

The steps below comprise the steps of conducting the "Mapping Outcomes" phase of a social return on investment analysis. This section is informed by available research on the social value of accreditation, focus groups conducted, a specific session focused on social return on investment, and information from local stakeholders in Ohio on the social value of accreditation of public health departments. The steps below come from the "Guide to SROI" published by Social Value International.[11]

Initial impact map

The first step of mapping outcomes is establishing objectives and scope of the program. Below is a table summarizing the objectives and scope of public health accreditation in the state of Ohio.

Social Return on Investment		
Organization	Public Health Accreditation Board	
Objectives	Support health departments to improve quality, accountability, and performance	
Scope	Activity	Public Health Accreditation
	Contract/Funding/ Part of Organization	State and local accreditation within state of Ohio
Activity	State and local PHAB accreditation within state of Ohio	

Identifying inputs

Inputs are the things stakeholders contribute to make a program possible. Below are key inputs identified during focus groups and the SROI stakeholder meeting.

- **PHAB application and annual fees.** While these were often mentioned as the least of the costs of accreditation, they nonetheless represent a cost associated with accreditation borne by local health departments.
- **Prerequisite activities.** These include conducting a CHA and CHIP and developing a strategic plan, the costs of collecting or purchasing data for the CHA, and the costs of hiring consultants for these activities, as needed.
- **Salary and benefits.** Hiring an accreditation coordinator or accreditation consultants comes with costs like any other staff expense.
- **Staff time.** Staff outside of those directly overseeing accreditation are needed to create and compile documents and policies, participate in accreditation-related training and meetings and give their time for other accreditation-related activities.
- **Lost revenue.** Staff time spent on accreditation represents an opportunity cost to health departments when time could be spent on fee-generating direct services and other services and programs that raise revenue.

Valuing inputs

One of the themes that emerged from conversations with stakeholders was the heterogeneity of inputs for local health departments of different sizes and levels of professionalism. Some discussion group participants said costs were high for small departments.

> *"Having worked in health departments of other sizes and in various parts of the state, I can tell you that many were caught flat footed."*

Discussion group participants said professionalism of the health department is another factor in how well they are able to handle the costs of accreditation.

> *"Organizational maturity is another factor. It's really about the leadership and what they are trying to do. So size is not the only thing--some small LHDs were prepared to be early adopters."*

Participants working at local health departments did not see accreditation fees as the primary cost of accreditation.

> *"The...lowest piece of the whole cost picture would be the accreditation fee."*

Input	Value
PHAB application and annual Fees	$1,299 Training Fee + $5,500-$22,400 Annual Fee depending on size.[12]
Prerequisite activities	One discussion group member, a local health department commissioner, estimated the cost of prerequisite activities for his department at $500,000.
Salary and benefits	The same health commissioner estimated his department had 1.5 FTE required for accreditation. Other considerations are salary, benefits, and staff time for PHAB and state agency staff overseeing accreditation.
Staff time	
Lost revenue	Data on lost revenue is more difficult to capture. Nonetheless, some participants in focus groups said that staff could be generating revenue if they were not participating in accreditation activities.

Clarifying outputs

Outputs are typically described as a quantitative summary of an activity. Since the results of accreditation are more process-based rather than program-based, this analysis focused on which specific public health capabilities rose to the top during focus groups when considering mentions by participants.

The most common capability participants mentioned was **performance management, quality improvement and evaluation**. Many participants said that PHAB accreditation raised the bar in performance management and professionalization of service delivery by departments.

> *"We have a performance management system now and we…provide it to all of the local health departments in the state. I don't know that we would do that if it wasn't for accreditation."*

The second-most common capability participants mentioned was **collaboration and partner relationships**. Often mentioned alongside this, though, was the fact that accreditation was happening across the state at the same time as the COVID pandemic. How much relationship-building happened due to accreditation and how much happened due to necessities of the crisis was an open question for many participants. Additionally, participants found estimating the impact of this relationship-building on public health outcomes to be difficult.

> *"Accreditation has helped us strengthen relationships with partners, so it probably impacts our collective ability to make a difference in the community's health, but that's really difficult to measure."*

The third-most common capability participants mentioned was **communications**. Participants mentioned that they were able to think more strategically about how they communicated and improve brand visibility due to standards set during accreditation

> *" I'm not sure that public health would have been that visible without some of what accreditation required us to do from our marketing and branding standpoints."*

Describing outcomes

Generally, when health departments are thinking of outcomes of their work, they are thinking of improved health outcomes for members of their community. The overall message we heard from focus and discussion group participants is that it is too early to tell whether accreditation will lead to better community health outcomes. Many participants were optimistic about the long-run prospect of accreditation leading to better outcomes for the general public.

> *"I was talking about programs in terms of generational change…which may be a 10 to 15 year time frame for us."*

One outcome participants working at local health departments wanted to see was using accreditation as a tool for the state to ensure its funds are being spent well and to invest in public health.

> *"An outcome I'd like to see would be a greater investment by the state into public health at both the state and local levels."*

Next steps

If PHAB is to conduct a full social return on investment analysis, they will need to work with a partner to conduct the other five elements of a social return on investment analysis. This means (1) taking a step back to establish scope and identify stakeholders, (2) evidencing outcomes and giving them a value, (3) establishing impact, (4) calculating the social return on investment, and (5) reporting, using, and embedding.

Appendix C 21ST CENTURY PUBLIC HEALTH LEARNING COMMUNITY

How has participation in the 21st century learning community supported health department transformation in Ohio?

Starting in 2017, Ohio was among the first members of the **21st Century Learning Community (21C)**, *a network of 19 states that exchanges insights and methodologies aimed at modernizing the public health system.*[13] *Within this network, Ohio's public health leaders have engaged with counterparts from other states to craft a cost analysis model and practical resources essential for navigating the implementation of PHAB accreditation requirements.*

21C began with three states — Ohio, Oregon and Washington — to address the chronic underfunding of public health by assessing the costs of foundational public health services (FPHS) needed in state and local health departments (LHDs). As more states have joined, 21C has played a critical role in facilitating collaboration across states to drive system transformation.

Key-informant interview findings about the 21st Century Learning Community

HPIO conducted two key-informant interviews with two focus group participants to discuss how public health system transformation has been impacted by the 21C. Informants highlighted how the 21C has provided opportunities for participants to collaborate and develop concrete tools that support LHDs implementing public health transformation efforts like models to estimate the cost of providing FPHS.

Cost analysis model

Through 21C, public health leaders in Ohio developed a "**costing model**" to determine the level and cost of FPHS currently provided, what gaps exist and the costs of closing those gaps. According to key informants, the costing tool has become popular in Ohio and other states, such as Wisconsin, New Jersey and Nebraska. The tool has clarified how LHDs should interpret, represent and collect data, addressing variability and a lack of standardization in previous Annual Financial Report (AFR) models.

The costing model, particularly the financial gap analysis, has been impactful in communicating the funding needs of public health systems to policymakers.

> *"…it has helped us in our status with the legislature and* ***convincing them we're worth an additional investment****."*

> *"If you're sitting with a legislator and you get them to say public health is important, the next question they ask is 'how much do you need and what do you need it for?' Now we have a credible assessment to say, for example, 'our biggest gap is communicable disease and it looks like we're going to need $5,000,000 to close that gap'. We might only get a million to start with.* ***The costing tool got us to the next level*** *to be able to answer those questions because you can't just go in and say we just need money because we need money to do good work. 'How much money?' 'As much as you got.' That doesn't work, so now the costing tool gives us dollars and topics."*

Information sharing among states

Both key informants reported that 21C has provided opportunities for states to share ideas. The 21C network is viewed by informants as an internal working group to guide implementation of public health standards by sharing projects, comparing approaches and standardizing assessments. In some cases, states learned they were working on similar projects and were then able to collaborate to standardize measures, promoting stronger alignment across states.

Through 21C convenings, participants gain an enhanced understanding of the strategies other states are using to transform public health funding, legislative advocacy and assessment. One key informant shared how, for example, collaboration in 21C has improved efficiency through increased use of shared services. Attitudes about shared services from more cautious health departments changed when they learned how other departments were doing it successfully.

> *"As every new state came in, **they brought something to the table**, something that they had been doing that moved public health forward."*

> *"If we weren't involved in this project nationally, **we wouldn't have a line of sight on important issues**. We know what the situation is here in Ohio, but we wouldn't have any idea how it compares to what's happening in other states, who's involved."*

> *"It's still critical for the modernization that we're all talking to one another—state to state. And when states have successes, **we can understand what they've done and hopefully replicate those and share best practices** because in the public health system across the U.S., there is no state that has the perfect public health system or perfect funding. We all have a lot of work to do to move it into the 21st century."*

Concrete tools and guidance for implementation

21C has been a driving force moving public health system transformation efforts forward by developing, applying and evaluating concrete tools that guide implementation. Similar to PHAB accreditation, the models have supported performance management, quality improvement, assessment and evaluation. According to the key informants, as methodologies improve and more health departments adopt new procedures, transformation will occur.

> *"The reason we do all these things is so that eventually we're in a place where we can impact health outcomes, because that's what we're all about. A lot of what we've been doing, whether it's through mandatory accreditation or the 21C project and some of these assessments, they have **focused on process, procedure, and building infrastructure**. We're not quite to that piece yet where we can say we're actually impacting outcomes, but we're putting all the pieces in place so that we can measure that and will be able to say in the future, we did X and Y, and this resulted in Z. We'll be able to show that it resulted in this particular impact or outcome."*

> *"21C has been very helpful to Ohio in carving out **what the local health department has to do, and then how we do it,** and mostly with the accreditation process. Accreditation has a lot of places where you're supposed to be engaging your community, your other public health partners, and I think that's given us a road map or a nice little plan or blueprint on how you reach out to the healthcare system. How do you reach out to your community partners? Well, there's **now guidance about how to do that in an effective systematic way**. I mean, health departments have always done those things, but with 21C we're able to put it into a framework and a process where we can measure it better and be able to see where our gaps might be."*

Appendix D

NACCHO PROFILE FINDINGS ABOUT CHAs, CHIPs AND STRATEGIC PLANS

The National Association of City and County Health Officials (NACCHO) administers a survey of local health departments (LHDs) that includes questions about community health assessments (CHAs), community health improvement plans (CHIPs) and strategic plans. LHDs are required to develop these three documents to become eligible for accreditation. The CHA and CHIP must involve collaboration with community partners.

Figure D.1 describes CHA, CHIP and strategic plan completion by accreditation status. There were no statistically significant differences in LHDs' completion of CHAs, CHIPs and strategic plans across PHAB accreditation status. Irrespective of when an LHD achieved PHAB accreditation, most agencies who responded to the 2019 NACCHO survey reported completing a CHA, CHIP, and strategic plan within the past three years while the remainder had completed their CHA, CHIP, and strategic plan in the past three to five years. Similarly, engagement with local nonprofit hospitals around the federal required community health needs assessment (CHNA) was high, irrespective of PHAB accreditation status. More than 90% of LHDs reported that they were either collaborating or discussing CHNA-related collaboration with nonprofit hospitals in their communities.

Figure D.1. **Completion of CHA, CHIP, and strategic plans for Ohio local health departments, by accreditation status, SFY 2019**

	Early adopters (2013-2017) (n=13)	**Later adopters** (pre and post-COVID; 2018-2023) (n=38)	**Not accredited** (n=10)
CHA			
Completed within past 3 years	84.6%	92.1%	100.0%
Completed within past 3 to 5 years	15.4%	7.9%	0.0%
CHIP			
Completed within past 3 years	76.9%	94.7%	100.0%
Completed within past 3 to 5 years	23.1%	5.3%	0.0%
Strategic plan			
Completed within past 3 years	84.6%	84.2%	100.0%
Completed within past 3 to 5 years	15.4%	15.8%	0.0%
CHNA collaboration with nonprofit hospitals			
Collaborating	91.7%	100.0%	88.9%
Discussing collaboration	0.0%	0.0%	11.1%
Not collaborating	8.3%	0.0%	0.0%

Notes: Due to missing data, the sample size was 61/111 LHDs (55%). Table shows percentage of LHDs in each category. ANOVA indicated no statistically significant differences in any of the variables examined across accreditation status at $p<0.05$.
Source: 2019 NACCHO Profile survey

NOTES

1. As of October 2023, 78% of Ohio LHDs were accredited. Ohio, therefore, ranked 2nd highest for accredited health departments, behind the District of Columbia, and is the state with the highest proportion. 2024 *Health Value Dashboard*, Health Policy Institute of Ohio.
2. Ibid.
3. Health Policy Institute of Ohio. 2024 *Health Value Dashboard*. April 2024.
4. Health Policy Institute of Ohio. "Ohio Public Health Basics," January 2013.
5. There have been a total of nine transitions with seven individuals named as directors or interim directors. One individual served as director or interim director three times.
6. PHAB accreditation involves several initial steps, as described **here**.
7. Data for 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 PHAB accreditation pipeline.
8. Correlation analysis was used to identify characteristics to include in this table. The correlations between these characteristics and accreditation status were statistically significant (alpha=0.05).
9. May 26, 2022 memo to ODH Subrecipients from ODH clarifies deliverable guidance for subgrant programs that began July 1, 2022 onward.
10. HPIO used the Ohio Medicaid Assessment Survey county typology.
11. "The Guide to SROI," Social Value International, January 2012, Accessed March 29, 2024, https://www.socialvalueint.org/guide-to-sroi
12. PHNCI published an Ohio case study on their website and OPHP is published in the Journal of Public Health Management and Practice, May/June 2018 Supplement "Ohio Statewide Efforts to Align Public Health and Health Care Population Health Planning." More information about these projects can be found at: **21C State - Ohio - Public Health Accreditation Board (phaboard.org)**
13. "PHAB Accreditation Fee Schedule," Public Health Accreditation Board, Effective July 1, 2022, Accessed March 29, 2024, https://phaboard.org/wp-content/uploads/Version-2022-Fee-Schedule.pdf

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