HHS Public Access

Author manuscript

J Public Health Manag Pract. Author manuscript; available in PMC 2017 November 15.

Published in final edited form as:

J Public Health Manag Pract. 2014 ; 20(1): 98–103. doi:10.1097/PHH.0b013e31829ed746.

A Study of Incentives to Support and Promote Public Health Accreditation

Ms Lee Thielen, MPA, **Dr Marilyn Leff, MSW, MSPH, PhD**, **Ms Liza Corso, MPA**, **Ms Erinn Monteiro, MPH**, **Ms Jessica Solomon Fisher, MCP**, and **Mr Jim Pearsol, MEd**

Thielen Consulting, Fort Collins, Colorado (Ms Thielen and Dr Leff); Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, Division of Public Health Performance Improvement, Atlanta, Georgia (Ms Corso); National Association of County & City Health Officials, Washington, District of Columbia (Mss Monteiro and Fisher); and Association of State and Territorial Health Officials, Arlington, Virginia (Mr Pearsol)

Abstract

Context—Accreditation of public health agencies through the Public Health Accreditation Board is voluntary. Incentives that encourage agencies to apply for accreditation have been suggested as important factors in facilitating participation by state and local agencies.

Objective—The project describes both current and potential incentives that are available at the federal, state, and local levels.

Design—Thirty-nine key informants from local, state, tribal, federal, and academic settings were interviewed from March through May 2012. Through open-ended interviews, respondents were asked about incentives that were currently in use in their settings and incentives they thought would help encourage participation in Public Health Accreditation Board accreditation.

Results—Incentives currently in use by public health agencies based on interviews include (1) financial support, (2) legal mandates, (3) technical assistance, (4) peer support workgroups, and (5) state agencies serving as role models by seeking accreditation themselves. Key informants noted that state agencies are playing valuable and diverse roles in providing incentives for accreditation within their own states. Key informants also identified the Centers for Disease Control and Prevention and other players, such as private foundations, public health institutes, national and state associations, and academia as providing both technical and financial assistance to support accreditation efforts.

Conclusions—State, tribal, local, and federal agencies, as well as related organizations can play an important role by providing incentives to move agencies toward accreditation.

Keywords

incentives; public health accreditation

Correspondence: Lee Thielen, MPA, Thielen Consulting, 1308 Lindenwood Dr, Fort Collins, CO 80524 (leethielen@aol.com).

The authors declare no conflict of interest.

Voluntary accreditation of public health agencies, launched in 2011 by the Public Health Accreditation Board (PHAB), requires adherence to national standards focused on public health infrastructure, completion of prerequisites, and payment of fees.[1] As with any accreditation program, time and resources are needed for an agency to achieve accreditation. Noting that the PHAB accreditation program is voluntary and not all health agencies have the resources for accreditation, the Exploring Accreditation Project established a work-group to explore the issue of incentives for accreditation. This group noted the importance of incentives at all levels of the public health system.[1] The goal of this project was to describe incentives that are currently being used or could be used by multiple agencies to encourage accreditation.

In his review of health and social service accreditation programs, Mays found that achieving widespread adoption of a voluntary accreditation program depended largely on "the strength of the incentives faced by the organization within the industry to pursue accreditation."[2](p10) A survey of state and local health departments by Davis et al[3] found that these agencies valued the same types of incentives: financial incentives, support for infrastructure and quality improvement (QI), and grant application ease and flexibility. Local health departments also noted technical assistance as a powerful incentive. Incentives such as marketing and recognition were second choices as motivating incentives. Some incentives support or create a clear benefit of accreditation for the organization (eg, recognition as a quality agency, adherence to law or regulations) and others remove barriers that prevent or hinder an organization from seeking accreditation (eg, funding or technical expertise to complete the application process).

This recognition of the need for incentives raises the questions of who could provide the incentives and what they are. State agencies and Tribal Area Health Boards (serving multiple tribes) are often in a good position to encourage or support local or tribal activities. The importance of the state providing such leadership is written into the PHAB Standards and Measures.[4] For example, Measure 1.4.3S acknowledges that much of the data needed by local public health comes from the information systems of the state health agency.

States typically receive funding for many different programs from federal agencies and others that can be used by the state agency or passed through to local public health departments. Funding provided by the Centers for Disease Control and Prevention (CDC) to health departments through its National Public Health Improvement Initiative (NPHII) in 2010 provided a new opportunity for states and other grantees to support accreditation readiness, performance management, and QI efforts. This program provided $76 million in funding in 2010 and 2011 to 76 state health departments, large cities, territories, and tribes to improve health outcomes by improving the infrastructure of public health in their jurisdictions.[5] States and tribes have used NPHII funding to support local jurisdictions by providing training and technical assistance on accreditation preparation and QI. In addition, state health agencies have, in some cases, provided direct financial support to local agencies and supported peer collaboration for accreditation.[5]

Other incentives for encouraging public health accreditation have emerged since the earlier studies on incentives. These include the development of various legal mandates at the state

level to encourage either accreditation or the completion of the prerequisites for accreditation[6] and the funding by private foundations and CDC of related grant programs that encourage performance improvement and the preparation for accreditation. Support from CDC and the Robert Wood Johnson Foundation (RWJF) for QI and preparation for accreditation has allowed many public health agencies to begin QI projects and to complete one or more of the prerequisites for PHAB accreditation. Technical assistance by national associations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County & City Health Officials (NACCHO), the National Association of Local Boards of Health, and the American Public Health Association, has been a major factor in allowing agencies to prepare for accreditation.

This study sought to understand incentives that have been used since accreditation was launched by interviewing local, state, tribal, and federal public health leaders, with special emphasis on state to local incentives. The interviewees were asked about incentives that were being used at all levels; we also asked what other incentives would be useful in helping their agencies become accredited. With 2 years of funding from NPHII and other sources, it is possible to describe how various agencies have chosen to support accreditation and provide meaningful incentives through this and other funding.

Methods

Key informants were interviewed to describe how numerous agencies are using incentives for voluntary accreditation. Informants were chosen on the basis of referrals from national groups as well as the authors' own knowledge and experience. The qualitative interviews were conducted with 39 public health professionals and leaders involved in federal, state, tribal, and local public health agencies from March 21, 2012 through May 8, 2012. Those interviewed included leaders from local (8) and state (17) public health agencies, state public health association (1), tribal health agencies (3), and academia (1). These represented 17 different states, 7 local public health agencies, 14 state public health agencies, 2 tribal agencies, 1 state public health association, and 1 academic public health institute. In addition, 9 staff in CDC's Office for State, Tribal, Local and Territorial Support and staff related to NPHII and health department accreditation efforts provided information and state examples. Those interviewed at the local level were primarily local health agency directors while those interviewed at the state level were primarily performance improvement managers.

Interviews were open-ended; the authors had developed a list of topics to be covered for all interviews before starting this qualitative process. Respondents were asked to talk about incentives that were currently in use as well as discuss other incentives they thought would be helpful in working toward accreditation. Interviews were done by telephone and in-person.

For purposes of this study, incentives were noted as either providing a benefit to the agency or removing a barrier to the achievement of accreditation. Benefits could be tangible or intangible. Barriers included anything that makes achievement of accreditation difficult,

including time, fees, cost, completion of prerequisites, specific standards and measures, agency resistance, and so forth.

Results

Results below describe the various types of incentives in use or desired by these agencies and are categorized by those provided by states to support local jurisdictions, those provided by CDC, and those provided by other organizations.

Incentives that states are using to support local jurisdictions

Key informants described several different examples of incentives provided by state health agencies to support local health agencies that make accreditation a benefit for the agencies.

1. Several states adopted PHAB standards as their state public health standards. Washington and Colorado are examples of this strategy. Discussions have occurred in North Carolina and Michigan regarding accepting PHAB accreditation in lieu of state accreditation or as an enhancement to state accreditation.

2. Some respondents noted that their states have state laws and regulations that mandate key aspects of accreditation, such as health assessments, health improvement plans, and strategic plans for state and local jurisdictions. These respondents indicated that the use of the law, regulations, and other legal tools to create mandates for accreditation, or its prerequisites, supports accreditation efforts.

3. Some states link state funding to the completion of the prerequisites for accreditation. A number of states require progress on community assessments, health improvement plans, or strategic plans to receive state funding for the local capacity grants. Illinois, for example, has a requirement for completion of a community health improvement plan.

4. Directors of local health departments repeatedly said that states show support for accreditation by preparing for and seeking accreditation for the state agency themselves.

Respondents identified other state incentives that may help remove barriers to accreditation.

1. States provide direct financial support for local health departments to prepare for accreditation. Arizona, Montana, and New York have given grants to local health departments to prepare for accreditation.

   States have used both federal and state funding to provide financial incentives. These funds can be used for specific purposes, such as paying for the PHAB accreditation fees, paying for outside consultants, supporting the cost of an accreditation coordinator, or helping pay the costs for prerequisites. For example, Washington State has given six $10 000 minigrants to local health departments for performance management whereas Oklahoma has provided funding for local accreditation coordinators.

2. State health agencies provide training and technical assistance. Major barriers to seeking PHAB accreditation include a lack of capacity at the state and local levels, especially to complete the health assessment, health improvement plan, and the strategic plan that are required as part of the application for PHAB accreditation. Washington State has created 3 centers that are providing technical assistance and training across the state serving all local health departments. The Northwest Portland Area Indian Health Board provides training and technical assistance to 43 tribes in Idaho, Oregon, and Washington. Most states provide the local data needed for health assessments and health improvement plans. National Public Health Improvement Initiative funding from CDC has been used in 31 states and 1 tribe to provide support to local health departments for performance improvement.

3. State health agencies, such as Kentucky, have supported peer groups and peer learning. Whether called Learning Collaborative, Learning Circles, or Accreditation Teams, peer collaboration and support are powerful incentives. They help local health department staff by providing a safe environment in which to learn, ask questions, look for examples of good practices, and provide encouragement and peer counseling when the challenges look hard.

4. Respondents also noted that state health agencies with a history and philosophy of including local jurisdictions in planning and funding decisions are better able to leverage their relationships with the local health departments to support accreditation at the local level. For instance, Texas has the Public Health Accreditation Council of Texas, which includes local health department representatives and involvement by state staff. They have worked together to discuss questions such as Texas's support of PHAB accreditation. A lack of trust and weak communication between the state health agency and the local health departments create barriers to moving forward on system improvement.

5. Most states provide data assistance for local health departments. Some state health agencies (eg, Colorado and Florida) have allocated staff and resources to support local health departments in their community health assessments and their public health improvement plans.

Incentives CDC provides or could provide

Respondents emphasized CDC's critical role in accreditation acceptance and engagement. The NPHII funding has been used to improve the performance of public health agencies and systems by providing funding for performance improvement and accreditation readiness, as well as technical assistance. In addition, CDC has made strides to ensure that federal CDC program grant funding can be used to cover costs of accreditation, including fees, so long as activities align with the spirit of the funding mechanism.

Respondents suggested a number of additional ways that CDC can explore and make being accredited a benefit and advantage for state and local agencies. Potential incentives include:

1. streamlining the process for accredited agencies to apply for federal funding,

2. reducing the program reporting and grant requirements for accredited agencies,
3. providing “extra credit” for applications for funding from accredited agencies, for example, grant specifications that provide points for accredited agencies during scoring of grant applications,
4. providing increased flexibility in the use of programmatic funds for accredited agencies,
5. exploring the opportunity to arrange for spreading the cost of accreditation over multiple federal programs such as the Department of Agriculture and the US Health Resources and Services Administration,
6. disseminating information and success stories to state, local, and tribal agencies,
7. maintaining predictable funding for accreditation. Informants see the use of NPHII funding as key to the ability of states to engage in the arena of performance improvement and preparation for accreditation, and
8. targeting funding for accredited agencies. Soon there will be a pool of public health agencies that are accredited. Informants suggested that a pool of funding could be available only to accredited agencies.

Other players in incentives

Respondents mentioned other players who are helping with incentives for accreditation of public health agencies. These include public health institutes, academia, state and national associations, and private foundations.

1. National associations, with funding from CDC and RWJF, have been offering grants, technical assistance, and extensive training to their members. Examples of these grants include the NACCHO Accreditation Support Initiative, the NACCHO Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Project, the ASTHO National QI Demonstration Projects, the ASTHO SHIP Guidance and Resources, the National Network of Public Health Institutes Multi-State Collaborative on Quality Improvement and Accreditation, and the Community of Practice in Public Health Quality Improvement.
2. Respondents indicated that state associations are close to their members. These associations are viewed as excellent conduits for technical assistance, training, and support for peer accreditation teams and learning circles. The state affiliates of the American Public Health Association and NACCHO, for example, have shown their ability to support members in preparation for accreditation.
3. Private foundations support QI through funding of activities and accreditation fees. In North Carolina, the Blue Cross Blue Shield Foundation of North Carolina and The Duke Foundation have, with CDC, funded the North Carolina Center for Public Health Quality. The Kansas Health Foundation has been an important supporter of strengthening the public health system in that state. On the national level, RWJF has provided funding for accreditation since 2004.

Key informants noted that agencies are at different levels of acceptance and motivation related to accreditation. Training, technical assistance, and other incentives, regardless of who is providing them, have to be geared to where the agency is on a motivational continuum. For example, state staff identified the needs of specific local health departments as different when the agencies are ready versus those that are reluctant to prepare for accreditation.

Discussion

State health agencies can serve a very important role in improving the entire public health system. Whether in a centralized state where all or most of public health is run through a central office with state employees delivering services at the local level or in a decentralized state where local government controls the operations of public health at the local level, the state agencies are often in excellent positions to encourage or support efforts to strengthen that state's public health system.

Some of the more stable and compelling incentives that states can use for accreditation are those written in law or regulation. Two states, Vermont and Maine, specifically refer to national accreditation in their laws.[6] State laws and regulations that mandate health assessments, health improvement plans, or strategic plans for state or local jurisdictions take the guesswork out of when and whether these key public health strategies will occur.

States can also use financial incentives, the provision of technical assistance and training, and support to local peer groups to increase the number of local health departments that pursue accreditation. State health agencies can also set a powerful example by their own pursuit of performance improvement and accreditation. Tribal health boards serve the same role with the tribal communities in assisting tribes in preparation for accreditation. The Public Health Accreditation Board might consider incorporating a stronger role for state health agencies in supporting system improvement at the state and local levels into PHAB standards for state health departments.

Local health agencies are getting support for accreditation not only through state health agencies but also from other local health agencies. Local health departments are providing incentives for each other through peer support workgroups, reciprocal facilitation, shared templates, and joint training.

The Centers for Disease Control and Prevention is a key supporter for public health improvement. By supporting accreditation in a comprehensive way through funding of PHAB, funding of partner organizations that provide technical assistance and member support, and direct funding to health departments; incorporation of performance improvement and accreditation into expectations of CDC grants; support for accreditation by the CDC program offices; and general promotion of accreditation, CDC is viewed as being able to help move the national public health system along the path of accreditation. The responsibility of the state health agencies and tribal health boards to encourage and assist all public health agencies in their jurisdiction through NPHII and other federal funding could be clearer. This role could be reinforced through networking and educational opportunities for

performance improvement managers, NPHII guidance and support, and through the goals expressed in the future funding opportunity announcements. Other players, such as private foundations (eg, RWJF), public health institutes, and national and state associations also have a role in removing barriers and enhancing the benefits of accreditation.

An interesting finding from this survey of state and local health leaders was that they suggested incentives that would reward accredited agencies. For example, several leaders suggested that a powerful incentive would be for accredited agencies to have easier access to funding and fewer reporting requirements than nonaccredited agencies. Some states are already tying state funding to local agencies to accreditation preparation. The Exploring Accreditation Project Fees and Incentives Workgroup suggested that accredited agencies receive recognition when they are applying for federal grants or other foundation money.[1] Although not currently the case, some respondents expect that national accreditation will become a consideration for future funding opportunities.

Each local agency's readiness to pursue accreditation must be assessed to determine the most meaningful incentives. A study of rural health departments noted that inadequate staff knowledge and lack of a background in public health for some rural staff members were barriers to accreditation. Other organizations had the motivation to apply for accreditation but not the staff or financial resources to do so.[7] As with any effort, whether it is a community health assessment,[8] a QI project,[9] or a standards-based accreditation program,[10] it is important to assess the readiness and motivation for change. The PHAB Readiness Checklist is a useful tool.[11] State and tribal organizations need to be asking questions about where each local organization is on the readiness scale when they are making efforts to support accreditation at the local level.

No attempt was made to prioritize the incentives. Incentives should be custom designed to where each state, local, or tribal health department is in the accreditation process. With all new initiatives, there is a curve from early adopters or innovators to late adopters. This may be determined by incentives, availability of resources, leadership, and perceived barriers.

There were several limitations to this project. This study interviewed a limited number of respondents and did not include all states. The interviewees were not chosen randomly but were known to the organizational partners involved in the study due to their work in this area. While we provided examples of incentives, it is also possible that these incentives are being used in the 33 states that were not part of the sample and that there are incentives in use that we did not capture.

Conclusion

Incentives to support public health agency accreditation include those that enhance the benefits, such as a pool of funding that is available only for accredited agencies, and those that reduce barriers to achieving accreditation, such as funding the fees or providing resources, technical assistance, or training to support the process of accreditation. Incentives can often be tailored to a level of readiness and motivation to produce the best results. It will take a broad-based effort by many players and sectors to achieve the goal of having most of

the population served by accredited agencies, thus assuring residents that they can expect a certain level of services and performance from their public health agencies. Federal, state, and local agencies, as well as public health partners, have roles that can be powerful in moving the public health system forward.*

Acknowledgments

This project was funded by the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, through a cooperative agreement to the National Association of County & City Health Officials. The findings and conclusions presented here are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

A sincere thanks to the 39 public health professionals who were the key informants for this paper and to the National Association of County & City Health Officials, the Association of State and Territorial Health Officials, the American Public Health Association, and the Centers for Disease Control and Prevention that conceived the project and offered guidance and direction.

References

1. Exploring Accreditation Project Report. Washington, DC: Exploring Accreditation; 2006. Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments.
2. Mays, G. Can Accreditation Work in Public Health? Lessons Learned From Other Service Industries. Princeton, NJ: Robert Wood Johnson Foundation; 2004. http://www.phaboard.org/wp-content/uploads/CanAccreditationWorkinPublicHealth.pdf [Accessed January 23, 2013]
3. Davis MV, Cannon MM, Corso L, Lenaway D, Baker EL. Incentives to encourage participation in the national public health accreditation model: a systematic investigation. Am J Public Health. 2009; 99:1706–1711.
4. Public Health Accreditation Board. [Accessed January 23, 2013] Standards & measures, version 1.0. http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf. Published 2011
5. Centers for Disease Control and Prevention. [Accessed January 23, 2013] National public health improvement initiative. http://www.cdc.gov/stltpublichealth/nphii/about.html
6. Colorado Public Health Practice-Based Research Network. [Accessed January 23, 2013] An examination of state laws & policies regarding public health agency accreditation prerequisites. http://www.publichealthalliance.org/chachipresearch
7. Meit, M., Harris, K., Bushar, J., Piya, B., Molfino, M. Rural Public Health Agency Accreditation: Final Report. New Orleans, LA: The National Network of Public Health Institutes; 2008. http://www.norc.org/PDFs/Walsh%20Center/Links%20Out/NNPHI_Accreditation_FinalReport_528.pdf [Accessed January 23, 2013]
8. National Association of County & City Health Officials. Achieving Healthier Communities Through MAPP: A User's Handbook. Washington, DC: National Association of County & City Health Officials; 2011.
9. National Association of County & City Health Officials. [Accessed January 23, 2013] Roadmap to a culture of quality improvement preview. http://www.naccho.org/topics/infrastructure/accreditation/upload/QI-Roadmap-11-16-11.pdf. Published 2011
10. Davis MV, Reed J, Devlin LM, Michalak CL, Stevens R, Baker E. The NC accreditation learning collaborative: partners enhancing local health department accreditation. J Public Health Manag Pract. 2007; 13:422–426. [PubMed: 17563633]

*The full report of the study that includes specific examples of the various incentives and menus of the incentives can be found at http://www.naccho.org/topics/infrastructure/accreditation/upload/To-Be-or-Not-To-BeIncentives-Paper-doc.pdf.

11. Public Health Accreditation Board. [Accessed January 23, 2013] National public health department accreditation readiness checklists. http://www.phaboard.org/wp-content/uploads/National-Public-Health-Department-Readiness-Checklists.pdf. Published 2011