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Local Boards of Health Characteristics Influencing Support for Health Department Accreditation

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Abstract

Background—Local boards of health (LBoHs) serve as the governance body for 71% of local health departments (LHDs).

Purpose—To assess the impact of LBoH governance functions and other characteristics on the level of LBoH support of LHD accreditation.

Methods—Data from 394 LHDs that participated in the 2015 Local Boards of Health Survey were used for computing summative scores for LBoHs for domains of taxonomy and performing logistic regression analyses in 2016.

Results—Increased odds of an LBoH directing, encouraging, or supporting LHD accreditation activities were significantly associated with (a) a higher overall combined score measuring performance of governance functions and presence of other LBoH characteristics (adjusted odds ratio [AOR] = 1.05; $P < .001$); (b) a higher combined score for the Governance Functions subscale (AOR = 1.06; $P < .01$); (c) the “continuous improvement” governance function (AOR = 1.15; $P < .001$); and (d) characteristics and strengths such as board composition (eg, LBoH size, type of training, elected vs nonelected members), community engagement and input, and the absence of an elected official on the board (AOR = 1.14; $P = .02$).

Conclusions—LBoHs are evenly split by thirds in their attention to Public Health Accreditation Board accreditation among the following categories: (a) encouraged or supported, (b) discussed but made no recommendations, and (c) did not discuss. This split might indicate that they are depending on the professional leadership of the LHD to make the decision or that there is a lack of awareness. The study findings have policy implications for both LBoHs and initiatives aimed at strengthening efforts to promote LHD accreditation.

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Keywords

accreditation; continuous improvement; governance; health department; legal authority; local boards of health; oversight; partner engagement; policy development; resource stewardship

Voluntary accreditation of health departments through the Public Health Accreditation Board (PHAB) is among the important forces of change in public health practice today and is expected to lead to significant improvements in public health administrative and service delivery practices.^{1,2} All state, tribal, local, and territorial health departments are eligible for accreditation, although the majority of participation to date has been among local and state health departments. Accreditation involvement among the nation's diverse local health departments (LHDs) is especially interesting to assess, as it offers opportunities for analyzing the many factors at play that determine LHD accreditation activities. One of those factors is the role of the governing entity, which for many LHDs is a local board of health (LBoH).³

LBoHs serve as the governing entities for 71% of LHDs.³ The PHAB accreditation standards and measures directly address the important role of governing bodies; they include standards dedicated to "engagement with the governing entity" and requirements for the governing body to indicate approval for the initial accreditation application and to participate in the site visit.⁴ Therefore, LBoHs are potentially important allies in motivating LHDs to pursue PHAB accreditation,³ but the extent to which LBoHs play this role has been unclear.

PHAB accreditation is expected to lead to important benefits. Implementation of and adherence to accreditation principles and standards can lead to informed and evidence-based decision making, competitiveness for funding, workforce improvement, and, in turn, increased public recognition of LHDs' role and value.^{1,5-8} PHAB-accredited health departments already report that accreditation has led to numerous benefits. These benefits include health departments' improved collaboration with other health departments and with community partners, enhanced sense of accountability, improved awareness concerning the need for engagement in quality improvement (QI) initiatives, and shared understanding of organizational strengths and weaknesses outlined as a result of formal strategic planning.^{1,2} Also, some LHD leaders believe that accredited LHDs are more likely to receive future funding,^{1,9} and there is some evidence to indicate the protective effect of accreditation on funding.¹⁰

For a majority of LHDs, LBoHs play a role on issues concerning legal matters, policy, accountability, and resources.^{11,12} The quality, efficiency, and sustained excellence of health departments might be influenced by the effectiveness of the LBoH as their governing body. Effective LBoHs can improve the odds of LHDs' success in their mission through the proficient provision of the governance functions of policy development, resource stewardship, partner engagement, oversight, exercise of legal authority, and continuous improvement.¹³ Thus, LBoHs might play tangible roles in accreditation steps and outcomes.¹⁴

The pursuit of PHAB accreditation involves a substantial long-term investment of time and other resources.¹⁵ As LHDs usually have competing priorities and limited resources, they might need encouragement from governing bodies such as the LBoH to decide to engage in the accreditation process.³ Encouragement and support by the LBoH may also be critical, given that limited evidence exists about the return on investments and the negative impact of not seeking accreditation. In addition, LHDs are mandated to provide certain public health programs and services,¹⁶ so unmandated activities (such as accreditation preparation) may receive a lower priority.¹⁴

Specific studies on the extent to which LBoHs support LHDs' pursuit of accreditation are limited and inconclusive. Research has shown mixed results concerning the influence of LBoHs on LHDs' accreditation engagement and future inclinations. Presence of an LBoH in a jurisdiction was found to have a significant positive influence on accreditation engagement of LHDs by some studies,^{17–19} whereas negative impacts or no impact was reported by other studies.^{2,20,21} The studies' lack of clarity about the nature of LBoH influence may result from the studies' treating the question as a dichotomy—simply capturing the presence or absence of LBoHs.

This study fills an important gap in existing research by using the recently developed taxonomy of LBoHs^{13,22} and recent data to assess the impact of LBoH governance and other characteristics on LBoH support of LHD accreditation. LBoHs with high scores on governance and other domains of the newly developed LBoH taxonomy are expected to be more supportive of their LHDs' seeking accreditation because such LBoHs are more likely to be aware of the desirability of PHAB accreditation.

Methods

The study design is cross-sectional, based on a survey using a representative sample of LHDs across the United States. For this research, human participant protection was not required because this research used secondary data.

Data and sampling

This study is based on data from the 2015 Local Boards of Health Survey, conducted among LHDs by the National Association of County & City Health Officials (NACCHO). This study solicited responses of LHD administrators about the extent to which their LBoH is involved in various governance functions and included items on LBoH engagement in accreditation. The study population of 2048 LHDs with 1 or more LBoHs served as the sampling frame for a stratified random sample of 685 LHDs. For the sample selection, LHDs were stratified on the basis of the LHD's state and population size (<50 000; 50 000–499 999; or 500 000 people). To ensure a sufficient number of responses for analysis from LHDs serving larger populations, NACCHO systematically over-sampled larger LHDs. The survey was sent to the sampled LHDs using Web-based survey software during July–September 2015, resulting in 394 responses, for a response rate of 58%.

Measures

The primary dependent variable was measured using the question “Which of the following best describes your local board of health’s discussions about the PHAB’s accreditation program for local health departments?” The response categories included (a) has not discussed; (b) has discussed accreditation but made no recommendations about LHD participation; (c) has directed the LHD to seek accreditation; (d) has encouraged or supported the LHD to seek accreditation; (e) has discouraged the LHD from seeking accreditation; and (f) has prohibited the LHD from seeking accreditation. The survey instrument instructed respondents to select one of the applicable categories. For the multivariable analysis, these categories were recoded into the following:

- Has not discussed accreditation, discussed but made no recommendations, discouraged the LHD from seeking accreditation, or prohibited the LHD from seeking accreditation [combined (a), (b), (e), and (f) = 0]. The categories (e) and (f) could not be treated as stand-alone due to extremely small numbers (1% and 4%).
- Has directed, encouraged, or supported the LHD to seek accreditation [combined (c) and (d) = 1]

This research used as independent variables the 6 governance functions of LBoHs and a seventh domain measuring other LBoH characteristics, as operationalized by this research team in an LBoH classification (taxonomy) from an earlier study (presented in Appendix Table 1, available at <http://links.lww.com/JPHMP/A355>). The 6 governance functions developed by Carlson et al¹³ and endorsed by the National Association of Local Boards of Health (NALBOH) were (a) policy development, (b) resource stewardship, (c) legal authority, (d) partner engagement, (d) continuous improvement, and (f) oversight. The seventh domain consisted of LBoH strengths and characteristics (measured by 10 survey items/variables) such as frequency of LBoH meetings, board composition, and sources of community input on public health issues and initiatives.

In addition to the 7 domains, 2 summary measures were used as independent variables: (a) the overall scale of all 59 dichotomous variables collectively representing these domains, and (b) a subscale of governance functions consisting of 49 variables. All multivariable models were run separately for each domain and included 2 categorical variables as the control variables: population size of LHD jurisdiction (<50 000; 50 000–499 999; and 500,000 people) and the LHD governance relationship with respect to state health department authority—“state governed,” where the LHD is a unit of the state government (ie, centralized); “locally governed,” where the LHD is a unit of local government (decentralized); or “shared governance,” where there is shared responsibility in governance of the LHD by local and state authorities.

Analytical methods

Analyses for this study were conducted in 2016, using sampling weights to account for 3 factors: (a) disproportionate response rate by population size, (b) oversampling of LHDs with larger population sizes, and (c) sampling rather than the census approach. For multivariate analysis of the influence of LBoH governance functions and other

characteristics and strengths on LBoH support of LHD accreditation (a 2-category variable), 19 separate binary logistic regression models were computed. The first set of 9 regression models included the summary scales described earlier in the “Measures” subsection (presented in Table 2). Each of the 9 regression models included as control variables the population size of the LHD jurisdiction and governance of the LHD with respect to state authority. The additional 10 logistic regression models were computed with each individual variable from the “strengths/other characteristics of LBoH” domain and 2 control variables—population size of the LHD jurisdiction and governance of the LHD (Table 3).

Results

Table 1 and the Figure present descriptive statistics. The Figure indicates that most LBoHs fall in the middle and are equally split: approximately 30% had encouraged or supported accreditation, slightly more than 30% had discussed accreditation but made no recommendation, and almost 30% had not discussed (which likely includes those that are not aware of or familiar with accreditation). Very few LBoHs are discouraging (1%) or prohibiting (4%) accreditation.

Table 1 presents descriptive statistics about the LHDs. Distribution of LHDs by governance category with respect to state health agency authority shows that most LHDs (87.2%) in the sample had local governance arrangements. Most (67.7%) had 50 000 or fewer people in their jurisdiction, and a small proportion (4.2%) had a large size of population in their jurisdictions (ie, 500 000). The overall scale mean for all of the items was 19.4 (out of a maximum possible score of 59). The mean score for the Governance Functions subscale was 14.3 out of 49. The mean for the “other LBoH characteristics and strengths” domain was relatively higher (5.1 out of 10).

Table 2 shows odds ratios of whether LBoHs directed, encouraged, or supported LHD PHAB accreditation activities, after adjusting for population size and governance with respect to state health agency authority. Higher overall score on the LBoH taxonomy scale was strongly associated with increased odds of LBoHs having directed, encouraged, or supported LHD PHAB accreditation activities (adjusted odds ratio [AOR] = 1.05; $P < .001$). The association of the Governance Functions subscale with accreditation support reveals that the LHDs with a higher score for the Governance Functions subscale had improved odds (AOR = 1.06; $P < .01$) of their LBoH directing, encouraging, or supporting the LHD’s PHAB accreditation program.

Among all of the governance functions, continuous improvement was the only function associated significantly at $P < .05$ with LBoHs’ tendency to support LHD PHAB accreditation activities. After controlling for the population size and governance category, LHDs with a higher score on continuous improvement were significantly more likely to have an LBoH that directed, encouraged, or supported their PHAB accreditation program (AOR = 1.15; $P < .001$). Other governance functions had a weaker association with LBoHs’ tendency to direct, encourage, or support LHD PHAB accreditation activities, although none were significant. A positive association also existed between the score for LBoH characteristics and strengths and LBoHs having directed, encouraged, or supported LHD PHAB

accreditation activities (AOR = 1.14; $P = .02$). Larger population size and the shared governance category showed significantly greater odds of LBoHs supporting LHD PHAB accreditation in most of the models.

Logistic regression results for the 10 individual variables constituting the LBoH strengths/ characteristics scale show that 5 had significant association ($P < .05$) with LBoH level of LHD accreditation support (Table 3). LBoH characteristics with the strongest positive influence on LBoH tendency to support LHD accreditation included (a) LBoH size, wherein the LBoH had 5 or more members as opposed to fewer members (AOR = 2.57; $P = .02$), and (b) whether the LBoH actively sought community input on public health issues from public forums (AOR = 1.78; $P = .02$), Web sites or social media (AOR = 1.67; $P = .03$), or elected officials (AOR = 1.63; $P = .04$). LBoHs that had at least 1 elected member were less likely to support LHD accreditation than LBoHs that did not have any elected officials (AOR = 0.62; $P = .04$).

Discussion

The level of LBoH support for LHD accreditation indicates that most LBoHs are not taking a prescriptive stance toward accreditation (by either directing or prohibiting the activities), and for the large majority of LBoHs, there is an equal split among those that have not discussed, discussed but not recommended, or encouraged or supported accreditation. Only a very small percentage of LBoHs oppose LHD participation in PHAB accreditation. Recent studies suggest that for LHDs that do not intend to apply for accreditation, the perceived time and effort required are a barrier.^{2,21} Therefore, advice from these LBoHs about LHD accreditation participation may be influenced by the need to prioritize scarce resources. Given that governing bodies' support and awareness of accreditation are a barrier identified by some LHDs,³ substantial opportunities exist for raising awareness and engaging LBoHs in conversations about the value of accreditation. Those opportunities may lie at both the national (eg, through national and statewide associations) and local (through individual LHD leaders) levels. Although previous studies have not specifically focused on the level of LBoH members' support of LHD accreditation, some studies examining correlations between the presence of LBoHs and actual level of engagement of LHDs in PHAB accreditation show similar positive associations.^{15,17–19}

Findings from this study showed a significant positive relationship between the summary measure of LBoH governance functions (expressed as a scale) and LBoHs' tendency to encourage LHD PHAB accreditation. These results support the premise that higher-functioning LBoHs (especially those most engaged in the continuous improvement governance function) might value PHAB accreditation as an avenue for LHDs to improve their services and administrative practices. The standards and measures developed by PHAB are considered rigorous benchmarks for public health agency performance. The PHAB standards and process highlight areas in which governing entities such as LBoHs need to engage to further the accreditation efforts of LHDs.¹³ Securing accreditation (if feasible, given other competing priorities) may help demonstrate to stakeholders that an external body has validated LHD practices as consistent with nationally recommended criteria.

Results of this study indicate that “continuous improvement” was the strongest correlate (among the 6 governance functions) of LBoHs’ tendency to encourage LHDs to consider pursuing PHAB accreditation. All other governance functions were not significantly associated with accreditation support by LBoHs. This finding is in line with PHAB standards’ strong emphasis on QI. This emphasis may be valued by the LBoHs that are more involved in the “continuous improvement” governance function, making such LBoHs more likely to encourage LHDs to pursue accreditation.

Results showed that LBoH size was an important determinant of LBoH tendency to support LHD accreditation. Perhaps larger LBoHs have increased chances of including a member that is a champion or advocate of accreditation. LBoHs that sought input on public health issues from diverse sources, including public forums, elected officials, and Web sites or social media, had a greater tendency to support LHD accreditation. This finding may imply that LBoHs lean toward supporting LHD accreditation if they are open to understanding public health issues from the perspective of communities they serve and if they take into account the standpoint of elected officials concerned about those communities.

Limitations

This study has several limitations. The cross-sectional study design did not compensate for the lag time between the independent variables and the dependent variable, allowing assessment of only associations rather than any predictive role of the independent variables. The data about the LBoHs were collected from LHD executives and administrators, so the findings are from the viewpoint of LHDs and not that of the LBoH members. While the Governance Functions summary scale showed a significant association with the dependent variable signifying LBoHs’ role in promoting LHD accreditation, the association of individual governance functions with this dependent variable was nonsignificant, with the exception of the “continuous improvement” governance function. Future studies may consider examining which specific components of the governance scales had stronger association than the ones that did not. Also, comparisons between results of this study and previous, as well as future, studies may be made with caution due to increasing awareness and acceptance of accreditation, broader attention to PHAB requirements, and growing body of evidence about accreditation benefits.¹

Conclusions

Results indicate that LBoHs are not taking a strong prescriptive stance toward accreditation, although approximately 30% of LBoHs are encouraging or supporting it. Very few LBoHs are prohibiting or discouraging accreditation. These results, therefore, imply that many LBoHs depend on the professional leadership of the health department director and staff to decide about accreditation. Some LBoHs, however, might not have a sufficiently strong understanding of accreditation and are therefore unable to take a position. Other LBoHs might not be convinced about the value of accreditation. Future research is needed to collect more detailed, preferably qualitative, data on barriers for LBoH support of LHD accreditation activities.

Overall, the tendency to direct, encourage, or support LHD accreditation was higher among LBoHs with superior performance of governance functions. Among the 6 governance functions, continuous improvement had the most significant positive influence on LBoHs' support of LHDs' PHAB accreditation programs. Other characteristics and strengths of LBoHs, including board composition and source of community input for public health issues, also showed a significant association with LBoH support of LHD accreditation. This finding implies that it is not only the performance of the governance functions that makes LBoHs important allies regarding the encouragement of LHD PHAB accreditation but also the additional characteristics of LBoHs such as board composition, engagement with community, and presence of an elected official on the board.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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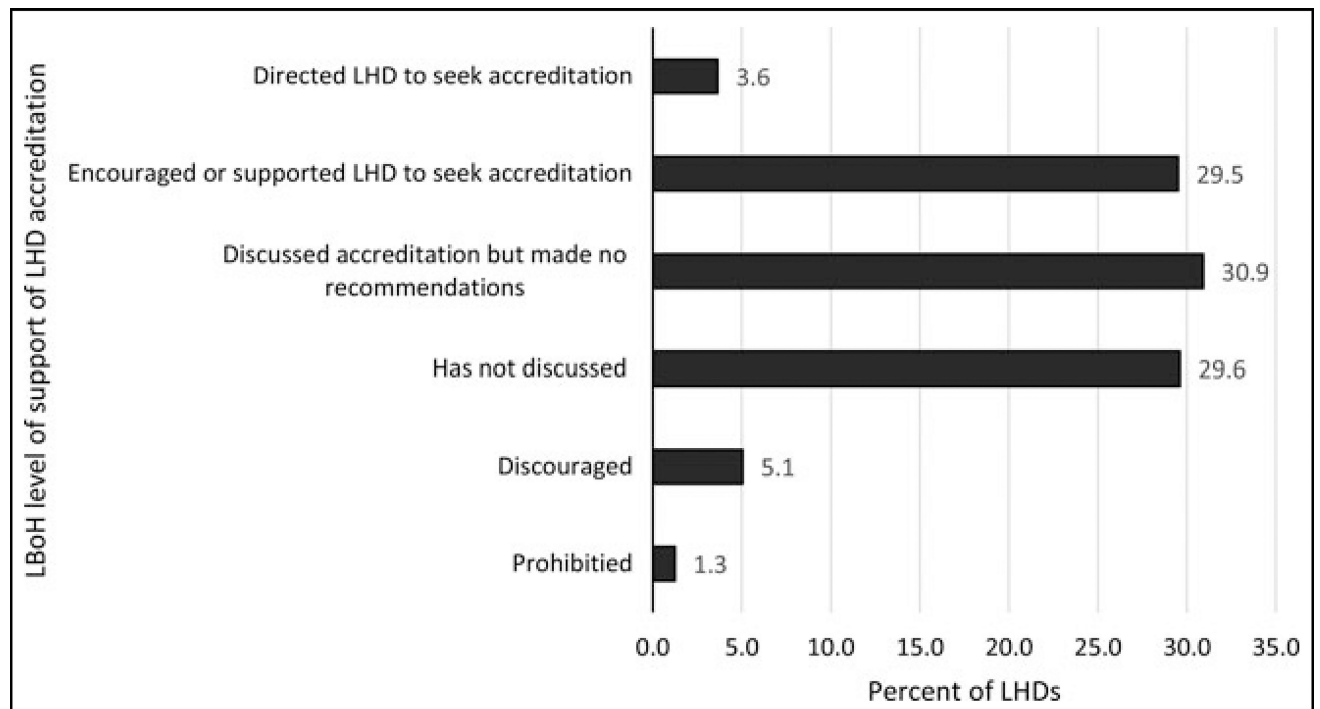
References

1. Kronstadt J, Meit M, Siegfried A, Nicolaus T, Bender K, Corso L. Evaluating the impact of national public health department accreditation—United States, 2016. *MMWR Morb Mortal Wkly Rep*. 2016; 65(31):803–806. [PubMed: 27513206]
2. Public Health Accreditation Board. [Accessed June 13, 2016] Public health agency accreditation system logic model. <http://www.phaboard.org/wp-content/uploads/AccreditationSystemLogicModel-Dec2013.pdf>. Published 2013
3. Shah GH, Leep CJ, Ye J, Sellers K, Liss-Levinson R, Williams KS. Public health agencies' level of engagement in and perceived barriers to PHAB national voluntary accreditation. *J Public Health Manag Pract*. 2015; 21(2):107–115. [PubMed: 25010327]
4. Public Health Accreditation Board. [Accessed April 7, 2016] Public Health Accreditation Board Standards and Measures version 1.5. <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>. Published 2013
5. Bender K, Halverson PK. Quality improvement and accreditation: what might it look like? *J Public Health Manag Pract*. 2010; 16(1):79–82. [PubMed: 20009649]
6. Blake R, Corso L, Bender K. Public health department accreditation and environmental public health: a logical collaboration. *J Environ Health*. 2011; 74(3):28–30. [PubMed: 22010331]
7. Gerding J, Carlson VP, Wilcox R. Public health department accreditation and environmental public health: sustaining the collaboration. *J Environ Health*. 2013; 76(1):56–57. [PubMed: 23947290]
8. Tilson HH, Bender KW, Kronstadt JL. Health department accreditation as a catalyst to foster the development of a future public health workforce. *Front Public Health*. 2015; 3:1–3. [PubMed: 25674556]
9. Meyerson BE, King J, Comer K, Liu SS, Miller L. It's not just a yes or no answer: expressions of local health department accreditation. *Front Public Health*. 2016; 4:1–7. [PubMed: 26870721]
10. Davis MV, Bevc CA, Schenck AP. Declining trends in local health department preparedness capacities. *Am J Public Health*. 2014; 104(11):2233–2238. [PubMed: 25211720]

11. Jones JA, Fenton GD. Composition and duties of local boards of health: findings from a 2011 national survey. *J Public Health Manag Pract.* 2012; 18(6):609–614. [PubMed: 23023287]
12. Patton D, Moon CE, Jones J. Describing local boards of health: insights from the 2008 National Association of Local Boards of Health Survey. *Public Health Rep.* 2011; 126(3):410–419. [PubMed: 21553670]
13. Carlson V, Chilton MJ, Corso LC, Beitsch LM. Defining the functions of public health governance. *Am J Public Health.* 2015; 105(S2):S159–S166. [PubMed: 25689187]
14. Wallace D, Tilson H, Carlson MVP, Valasek MT. Instrumental roles of governance in accreditation: responsibilities of public health governing entities. *J Public Health Manag Pract.* 2014; 20(1):61–63. [PubMed: 24322689]
15. Beatty KE, Mayer J, Elliott M, Brownson RC, Wojciehowski K. Patterns and predictors of local health department accreditation in Missouri. *J Public Health Manag Pract.* 2015; 21(2):116–125. [PubMed: 24722052]
16. Hoss A, Menon A, Corso L. State public health enabling authorities: results of a fundamental activities assessment examining core and essential services. *J Public Health Manag Pract.* 2016; 22(6):529–536. [PubMed: 27682724]
17. Chen L-W, Nguyen A, Jacobson JJ, Gupta N, Bekmuratova S, Palm D. Relationship between quality improvement implementation and accreditation seeking in local health departments. *Am J Public Health.* 2015; 105(S2):S295–S302. [PubMed: 25689200]
18. Shah GH, Beatty K, Leep C. Do PHAB accreditation prerequisites predict local health departments' intentions to seek voluntary national accreditation? *Front Public Health Serv Syst Res.* 2013; 2(3):4.
19. Luo H, Sotnikov S, McLees A, Stokes S. Factors driving the adoption of quality improvement initiatives in local health departments: results from the 2010 Profile Study. *J Public Health Manag Pract.* 2015; 21(2):176–185. [PubMed: 24978615]
20. Mays G, Beitsch LM, Corso L, Chang C, Brewer R. States gathering momentum: promising strategies for accreditation and assessment activities in multistate learning collaborative applicant states. *J Public Health Manag Pract.* 2007; 13(4):364–373. [PubMed: 17563624]
21. Yeager VA, Ferdinand AO, Beitsch LM, Menachemi N. Local public health department characteristics associated with likelihood to participate in national accreditation. *Am J Public Health.* 2015; 105(8):1653–1659. [PubMed: 26066930]
22. Shah GH, Sotnikov S, Leep CJ, Ye J, Van Wave TW. Creating a taxonomy of local boards of health based on local health departments' perspectives. *Am J Public Health.* 2017; 107(1):72–80. [PubMed: 27854524]

Implications for policy & Practice

- Findings about low overall LBoH support for LHD accreditation present an opportunity for public health leaders and policy makers concerned with encouraging accreditation of LHDs governed by 1 or more local boards. LBoH members often represent interests of health care and other relevant community stakeholders. Some of these members, though highly influential, are less interested in a particular aspect of LHD performance such as securing accreditation. They can be moved from low interest to high interest stakeholders' category through appropriate information, education, and communication strategies.
- Raising LBoH member's interest and support level for PHAB accreditation has potential implications for practice, including the possibility that pursuing accreditation will be formally included in the list of issues of high strategic priority in the strategic planning process and will have budget allocation. This is particularly pertinent for LHDs for LBoHs approve the LHD budgets.
- In many LHD jurisdictions, LBoHs serve as a voice of community stakeholders, which should make substantiating LHD accountability to the stakeholders (demonstrated through LHD accreditation) an important LBoH priority. Both NACCHO and NALBOH can serve as important players by furthering awareness about the support role of the LBoH during the LHD's accreditation.
- Presence of variation in LBoH's own continuous QI²² and association of LBoH's own QI with accreditation support imply that LHDs may benefit from supporting their LBoH's continuous QI, including training of members on topics of relevance such as budget development and training for members not from public health about public health issues and emerging trends. In turn, LHDs can expect benefits of having robust and strong LBoHs, which can effectively do resource stewardship and support LHDs innovations other than the mandated services such as LHD accreditation.

**FIGURE.**

Percentage of LHDs by Nature of LBoH's Discussions About the Public Health

Accreditation Board's Accreditation Program for LHDs Abbreviations: LBoH, local board of health; LHD, local health department.

TABLE 1

Descriptive Statistics for the Governance Functions and Other LHD/LBoH Characteristics

	All LHDs		LBoH Level of LHD Accreditation Support ^a	
	N (Not Weighted)	% (Weighted)	High %	Low %
<i>LHD/LBoH characteristics</i>				
Size of LBoH: Had 5 members (vs <5)	342	85.6	81.8	93.6
LBoH had at least 1 member from health care (vs none)	326	82.5	80.7	86.4
At least 1 member of LBoH had public health training (vs none)	205	52.3	48.7	60.0
LBoH had at least 1 elected member (vs none)	258	66.5	69.2	60.8
LBoH met 6 times per year (vs 5)	239	59.9	58.0	64.0
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Elected officials (vs No)	193	46.5	42.0	56.0
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Hearings (vs No)	85	20.3	18.2	24.8
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Public forums (vs No)	112	28.8	23.1	40.8
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Web site or social media (vs No)	123	32.0	27.8	40.8
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Print or broadcast media (eg, newspaper, TV, radio) (vs No)	129	32.9	31.8	35.2
LHD governance authority				
Local	332	84.3	84.8	83.2
Shared	28	7.2	4.9	12.0
State	34	8.5	10.3	4.8
Size of LHD jurisdiction population				
<50 000	216	216	68.2	44.4
50 000–499 999	145	35.1	29.5	46.8
500 000+	33	4.4	2.3	8.7
	Mean	SD	Mean	Mean
<i>LBoH governance and other characteristics scales</i>				
Scale for all taxonomy items (58) ^b	19.4	9.4	18.2	21.8
Scale for governance functions (48) ^b	14.3	8	13.3	16.2
Subscale for LBoH characteristics and strengths (other than governance functions) (10) ^b	5.1	2.2	4.8	5.6

	All LHDs		LBoH Level of LHD Accreditation Support ^a	
	N (Not Weighted)	% (Weighted)	High %	Low %
Subscale for policy development (8) ^b	2.2	1.9	2.2	2.2
Subscale for resource stewardship (6) ^b	2.2	1.5	2.1	2.4
Subscale for legal authority (8) ^b	2.6	2	2.5	2.8
Subscale for partner engagement (6) ^b	0.8	1.5	0.7	1.0
Subscale for continuous improvement (17) ^b	5.3	3.6	4.7	6.5
Subscale for oversight (3) ^b	1.2	0.9	1.1	1.4

Abbreviations: LBoH, local board of health; LHD, local health department; PH, public health; N, number of observations; SD, standard deviation.

^aHigh=LBoH directed, encouraged, or supported LHD efforts to seek accreditation; Low or none=LBoH prohibited, discouraged, or did not discuss accreditation, or discussed but made no recommendations.

^bNumber in the parenthesis indicates the total possible score for the scale/subscale.

TABLE 2

Logistic Regression of Whether LBoH Directed, Encouraged, or Supported LHD's PHAB Accreditation Activities, by LBoH Classification Domains

LHD Characteristics	AOR	<i>pa</i>	95% CI for AOR	
			Lower	Upper
Overall scale of LBoH taxonomy [59 items]	1.05	<.001	1.02	1.07
Population size of LHD jurisdiction (vs <50 000)		<.001		
50 000–499 999	2.40	<.001	1.50	3.84
500 000+	5.81	<.001	1.97	17.16
LHD governance with respect to state authority (vs state) ^b		.05		
Local	1.05	.92	0.40	2.80
Shared	2.88	.09	0.86	9.68
Governance Functions scale [49 items]	1.06	<.01	1.02	1.10
Individual domain subscales				
Policy Development [8 items]	0.96	.54	0.85	1.09
Resource Stewardship [6 items]	1.16	.07	0.99	1.36
Legal Authority [8 items]	1.08	.20	0.96	1.21
Partner Engagement [6 items]	1.14	.08	0.98	1.32
Continuous Improvement [18 items]	1.15	<.001	1.07	1.22
Oversight [3 items]	1.28	.06	0.99	1.64
Other strengths/characteristics [10 items]	1.14	.02	1.02	1.28

Abbreviations: AOR, adjusted odds ratio; LBoH, local board of health; LHD, local health department.

^aBoldface indicates statistical significance ($P < .05$).

^b“Local” means LHDs are units of local government (or decentralized); “shared” means that LHDs are units for which responsibility in governance is shared by local and state authority; and “state” means that LHDs are units of the state government (centralized).

TABLE 3

Logistic Regression of Whether LBoH Directed, Encouraged, or Supported LHD's PHAB Accreditation Activities, by LBoH Characteristics/Strengths

LBoH Strengths/Characteristics	AOR ^a	<i>P</i> ^b	95% CI for AOR	
			Lower	Upper
Size of LBoH: Had 5 members (vs below first quartile [ie, <5])	2.57	.02	1.15	5.76
LBoH had at least 1 member from health care (vs No)	1.57	.16	0.84	2.92
At least 1 member of LBoH had public health training (vs none)	1.49	.08	0.95	2.34
LBoH had at least 1 elected member (vs none)	0.62	.04	0.39	0.99
LBoH met 6 times per year (vs 5)	1.09	.72	0.67	1.79
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Elected officials (vs No)	1.63	.04	1.03	2.58
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Hearings (vs No)	1.24	.45	0.72	2.14
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Public forums (vs No)	1.78	.02	1.10	2.90
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Web site or social media (vs No)	1.67	.03	1.04	2.67
In the past 2 y, LBoH actively sought community input on PH issues/initiatives from: Print or broadcast media (eg, newspaper, TV, radio) (vs No)	1.13	.61	0.70	1.81

Abbreviations: AOR, adjusted odds ratios; LBoH, local board of health; LHD, local health department; TV, television.

^aAORs are from 10 different models; AORs for each individual characteristic of LBoH are adjusted for population size and type of LHD governance with respect to the state. The AOR and other statistics for the control variables are not presented in the table.

^bBoldface indicates statistical significance ($P < .05$).