Public Health Accreditation: Progress on National Accountability

In 2006, public health achieved a major milestone in its continuing quest for an accountable, distributed local delivery system. In cross-posted, coordinated announcements, the major leadership organizations in the field—the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), and the American Public Health Association (APHA)—declared their consensus in the Exploring Accreditation Project. Together, they concluded that voluntary accreditation is feasible, desirable, and strategically important to advance the shared goals of the field: to "improve and protect the health of the public by advancing the quality and performance of state and local public health departments" (2, 6).

This consensus emerged from more than a quarter century of progress in the way we in public health think about our field, the way we organize our agencies and systems, and the way we count what we do. These essential public health policy threads, now woven together, were carefully and independently spun (16).

THE THREADS FOR THE NEW TAPESTRY

The landmark report on the Future of Public Health, issued by the Institute of Medicine of the National Academies of Science (IOM) in 1988, delivered the clarion call to the nation to aid a public health system the IOM panel described as "in disarray" (8, p. 19). In its assessment of the state of public health, the IOM discovered a deplorable lack of reliability, even availability, of an identifiable local component of the public health system in many parts of the country and an unexplainable variability in configuration and performance in the rest of the country. The IOM report called on those responsible for advancing and supporting the system to develop and deploy consistent definitions of the scope of practice and clear and accountable metrics by which a local citizen, concerned about whether the local community was being adequately served, could identify and hold accountable the purported services and protections. The report declared, "No citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection, which is possible only through a local component of the public health delivery system" (8, p. 145).

The IOM committee reframed the mission of public health as "fulfilling society's interest in assuring conditions in which people can be healthy" (8, p. 7). And the committee created a new conceptual framework with which to comprehend the scope of public health's activities as core functions at all government levels: assessment, policy development, and assurance. Into that landmark IOM report a prior thread was woven to strengthen the fabric. *The Model Standards for Community Preventive Health Services* (1) were recognized as providing necessary materials with which to weave this new cloth. These standards, in turn, had undergone a ten-year development process under the leadership of the Centers for Disease and Prevention (CDC). They were initiated at CDC in response to the public health delivery system's failure in the United States to respond adequately or coherently to the substantial challenges in a short-notice nationwide immunization initiative against swine influenza in 1976. For each of the major content areas of public health practice, indicators recognizable and countable in any local community were identified through a consensus process deriving from the same leadership organizations now working together on accreditation.

As model standards, the proposal outlined the challenges to the local community using an open-ended, fill-in-the-blanks approach to modeling: By 19xx, the rate of problem Y will not exceed (or will be reduced to) Z. In association with the Healthy People 2000 undertaking, an effort at depicting benchmarks, the project developed either national averages or synthetic composite metrics from multiple reporting jurisdictions about each of the objectives in the *Model Standards*, now still part of the Healthy People publications (1).

In field testing these standards and their proposed benchmarks, however, CDC, through a strategic alliance with the APHA, found that local public health agencies had considerable difficulty with the concept of uniform standards for public health delivery, much less their application. The standards were based on community programs (e.g., by 1990 the community will be served by a comprehensive elder abuse prevention program) and community-level outcomes (e.g., by 1990 the frequency of reported elder abuse will be reduced to xx/100,000). The agencies assumed that those in governmental public health would facilitate community-level health program development and health care status improvement.

But could society, or even its elected governmental leaders at state and local levels, hold their health departments accountable for accomplishing such community-level programs and outcomes when so many actors and factors out of the official organized public health agency's control were driving these problems and decisions? And if the public health agency scored poorly on a community- or system-level public health assessment using these standards, how could those wishing to build the infrastructure prevent the reverse, e.g., that the staff (and particularly the director) would be punished rather than helped? And besides, public health agencies do not see themselves as funded to be research entities and often do not collect the data required for the public health community assessment function (or when the agency does these things, the data persons are the first to be eliminated in annual budget cuts).

These issues were presented to the panel developing the 1988 report and helped inform the IOM committee conclusion that mechanisms were needed for local (and state) agency accountability and for assuring the maintenance of adequate and equitable levels of service and qualified personnel. Among recommended mechanisms were such strategies as performance contracting between local and state agencies

and related negotiated local standards. The report specifically suggested that these standards could be based on *Model Standards: A Guide for Community Preventive Health Services* (8, p. 149). The scope of practice definitions from the *Future of Public Health* were widely embraced: Public health's role is to create conditions in which people can be healthy. That did not mean that the role was not to run a local health department. It meant that public health has the much broader mandate to be the organizer, aegis, and conscience of the community's public health system. Thus, the public health leader (health officer) needed to exercise a broad mandate of system leadership in addition to the traditional role of agency manager.

The IOM report outlined in detail what it meant by each of the core functions: assessment, developing and analyzing the data necessary to monitor, respond to, and improve health; policy development, translating these data into concrete protections, initiative, and programs to address gaps and needs; and assurance, ensuring that those responses were forthcoming in a quality-assured, competent, and accessible manner. Academia, severely criticized in the 1988 report for its neglect of public health practice in curriculum and in service, rallied to create education programs in public health practice and, under the guidance of the Faculty-Agency Forum, later the Council on Linkages between academia and practice, helped to fulfill the role foreseen by IOM for academia as part of this local practice system (14). Under the guidance of the Department of Health and Human Services (DHHS), the Public Health Functions Working Group developed a consensus definition of public health enumerating the Ten Essential Services of public health and worked diligently toward consensus adoption of these services as the way to understand public health in every community (15). Thus were spun two more important threads: the legitimacy of public health practice as scholarship and the concreteness of the concepts of the essential services.

The CDC's public health practice program office (PHPPO) developed the next steps in the *Model Standards* program by drafting, field testing, and then institutionalizing the necessary documents by which every community (no matter how small or remote) could perform a community assessment against descriptive benchmarks, rate itself, compare itself with a national data set of similar communities, and institute the process of continuous improvement, the Public Health System Performance Standards, and later, similar standards for local boards of health, state health agencies, and international use (see **http://www.cdc.gov**) (4).

The national-level practice leadership organization for local public health, the NACCHO, worked hard to change the usual *bon mot* (or old chestnut)—"if you've seen one local health department, you've seen one local health department"—to a much more enlightened philosophy of celebrating individuality but building on commonality. The result of this, building on the recommendations of the 2003 IOM report (7), was a productive effort to develop a national consensus on an operational definition for local public health, resting on the concepts of the essential local agent to deliver on the 1988 vision of government's responsibilities, which cannot be delegated, and the Ten Essential Services (12).

These sentinel events were celebrated when the IOM convened in 2001 for a second major national look at the public health system. This committee observed that the consensus had progressed dramatically since the first assessment and that the time was now right to consider whether and, if so, how best to move toward a

coherent nationwide system to assure the citizens of "every community, no matter how small or remote," access to the vital local public health services.

The new IOM committee recognized a series of uncertainties and challenges concerning accreditation. Local public health is inherently local. Thus there is a deep-seated resistance to efforts to remove local control or somehow dictate or control things from other government levels. Furthermore, public health workers laboring in the local communities know their major limitations by virtue of limited budgets, mandates and political will, and forces essentially outside their control, particularly among many of the root causes of ill health, poverty, discrimination, and cultural roots, which run deep. With these in mind, how can an accrediting authority review a local agency's efforts?

Nonetheless, the IOM committee believed that greater accountability was needed and that the coherent public health system could pull together to provide it. They advocated development of a uniform set of national standards leading to public health agency accreditation in hopes that the intervening progress made such standards feasible. IOM issued a caveat, however: Two major limiting factors in creating uniform standards and the resulting equities were grave underfunding and the need for "adequate, consistent, and sustainable funding for the governmental public health infrastructure" (7, p. 160).

The IOM and many other advocates saw that accreditation could be done in such a way as to recognize local unique situations but still achieve the dual purposes of accountability and continuous process improvement. They based this position on what they observed to be a breakthrough concept, the National Public Health System Performance Standards, which "provide a way to conceptualize the system as the unit of accreditation and, from there, to evaluate the role of the agencies in facilitating the work of the system" (7).

GETTING ON WITH WEAVING THE THREADS TOGETHER

To get the process moving, in 2003, the IOM recommended that the Secretary of the DHHS should appoint a national commission "to consider if an accreditation system would be useful for improving and building state and local public health agency capacities" (7, p. 158) The committee further recommended that if the commission reported affirmatively, then it should make recommendations on several key unresolved issues, such as governance, incentives, and strategies to engage state and local government leadership. The IOM recommended that membership on the envisioned commission would include representatives from the CDC, the ASTHO, the NACCHO, and nongovernmental organizations (7). The response to this clear strategic opportunity was remarkable. These leadership groups did not wait for the formal naming of a commission. They created a consortium of the NACCHO, the ASTHO, the NALBOH, and the APHA, with funding and support from the CDC and the Robert Wood Johnson Foundation (RWJF), and launched the ambitious and creative Exploring Accreditation project.

Through an extensive process, which included public hearings, literature reviews, model building, and multidisciplinary team exploration, the national consortium's steering committee led the course of this project over two years to its conclusion. The result was the working draft of the project's report and "a proposed model for a Voluntary National Accreditation Program for State and Local Public Health

Departments" in May 2006 (see **http://www.exploringaccreditation.org**). As a partner project, the RWJF funded a multistate learning collaborative among states already conducting efforts to measure, assure quality, and credential (accredit) local public health agencies to understand and learn from the various existing approaches and inform the national policy development (3). Varying approaches were studied across the country, including Illinois, Michigan, Missouri, North Carolina, and Washington state. Lessons learned were pooled to create a single national vision.

A national dialogue was created through public hearings (including a town hall meeting), a nationally broadcast teleconference, and an open Web site (**http://www.exploringaccreditation.org**), resulting in the issuance of a final consensus report (6).

The conclusions from these deliberations wove together the threads cumulatively spun by the preceding efforts. Accreditation is a very promising tool by which to make explicit the implicit guarantees of public health. The metrics for accreditation are generally those that were foreseen by the efforts of the CDC and other agencies from 1978, although, of course, they need reconciliation among competing approaches. The framework for new standards emerged from the Ten Essential Services as envisioned by the public health working group, factored into an operational definition. The domains for accreditation are the same for state-level and local agency review, although the actual expectations would differ depending on their complementary roles. Beyond the Ten Essential Services domains, the final report included an eleventh domain reflecting the expectation of excellence in agency management.

To guide these processes, the Exploring Accreditation project developed an explanatory model. At the core of this model is the shared goal, reflecting the prior 30 years of gathering consensus: to improve and to protect the public's health by advancing the quality and performance of state and local public health departments.

In this model, the basic objectives are summarized under the broad question, Why accreditation now? The project (in the model) outlines a series of broad objectives, building on the visions of the IOM and the other leadership organizations. The time is now right. With the new tools and the power of the new consensus, accreditation, done effectively, can now help the field achieve the shared visions woven into the fabric over the many years of accreditation's creation, but with the focus on achieving improved health.

The report asked, What is the value of the program? Again, the vision weaves together the prior threads from improved visibility and credibility to create a climate of continuous process improvement. The project identified recommendations for governance, eligibility, standards development, and conformity assessment, summarized to answer the question, How would the program run? And then, the report asked the financing question. Development of a thorough and accountable process that is evidence based and process driven takes time, its own discipline, and the resources to staff and operate it. This, in turn, has led the group to develop a business case for accreditation: The benefits must exceed the costs, and indeed, a strong case to this effect is made by the project.

The consortium issued a comment draft, held extensive hearings, and created a final report (6) as the final stitch to the fabric at the end of 2006, again posting it and helpful answers to frequently asked questions on the Web site

(**http://www.exploringaccreditation.org**) now well familiar to the practitioners in the field. The final 90-page report was issued in Winter 2006/2007. And the participating organizations endorsed all the recommendations carefully, by intent, using the same language to endorse the recommendations "in order to show collective commitment from the practice field for moving forward with voluntary accreditation for state and local health departments" (see **http://www.naccho.org**).

Immediately following this landmark event, the same partners organized to form the Public Health Accreditation Board (PHAB). The vision in the early implementation stages was that this board would not duplicate or compete with the practices and products of state-level accreditation efforts already under way. One possible complementary effort, for example, would be to consider carefully reviewing and deeming those processes if they could be shown as equivalent to those offered directly by the PHAB. The vision, eventually, would be to provide a single set of consistent, national-level accreditation activities: counseling, self-assessment, and peer-assessment processes (5).

Of course, reviewing the experiences with accreditation in other sectors reminds us that many challenges remain unresolved to implement the recommendations for public health accreditation (9, 13). Accreditation of the official public health agencies cannot guarantee effective functioning of the larger public health systems in which they operate, any more than accrediting hospitals can achieve health care reform. An accredited public health agency, like an accredited hospital, can still underperform or experience serious quality-control problems. Witness America's recently exposed epidemic of medical errors in hospitals (10). Poor political and fiscal support can still plague systems as it does public schools and school systems despite years of accreditation efforts. Stronger (i.e., accredited) agencies alone cannot guarantee stronger (i.e., more competent and effective) staff. Proper staffing requires recruiting and training the public health workforce. Credentialing of that workforce represents an important effort, parallel to accreditation of the agencies in which they work. And the process of continuous improvement requires continuous knowledge development. The underfunded public health systems research agenda must not be allowed to languish, lest accreditation lock us in to yesterday's vision, rather than building toward tomorrow's (11).

THE FINISHED FABRIC

Accreditation is a promising forward step toward achieving the national objective of a high-performance delivery system for the public health and preventive medicine services. Throughout the accreditation process, a series of key concepts and unifying themes have emerged.

- To deliver on the promise of health protection in every community, public health must have a consistent strategy to achieve all ten of the essential public health services.
- To keep accountable to the broader public, this strategy needs to be explicit, gaps identifiable, goals clear, priorities unambiguous, responsibilities pinpointed, and progress measurable.
- With consistent measurement can come benchmarks to quantitate progress toward agreed-on standards and to permit cross-jurisdictional comparisons.

- When agreed norms are met or exceeded, a process, such as accreditation, which recognizes this progress, can provide a useful platform for community organization and continuous improvement. The accredited agency can provide the required leverage for overall system improvement.
- When major shortfalls from agreed-on norms can be identified, a remedial plan can be specified and the incentives to implement that plan established to bring deficient agencies and underserved communities up to acceptable standards.
- Agencies meeting standards can be given incentives for continuous improvement and offered funding and opportunities witheld from agencies unable to attain accreditable status until the latter is brought up to standard. In shorthand, incentives and remediation, carrots and sticks, are critical components and must be adequately resourced.

For the field, having come so far so fast, to weave together a whole new cloth with the threads of consensus, which have been strengthened by the test of time—a new vision built on the old visions, new definitions emerging from long-standing consensus, new and clearer scope evolving from the power of the agreements following the vision of the IOM, new tools and accountabilities spun from the tough yarn of hard-won standards—surely for this wonderful fabric of public health, accreditation of public health agencies will provide the protective cloak of public health to every community in our nation, an idea whose time has come.

LITERATURE CITED

1. Am. Public Health Assoc./Assoc. State Territ. Health Off./Natl. Assoc. County Health Off./U.S. Conf. Local Health Off./Cent. Dis. Control Prev. 1985. *Model Standards: A Guide for Community Preventive Health Services*. Washington, DC: Am. Public Health Assoc. 2nd ed.
2. Bender K, Benjamin G, Fallon M, Jarris P, Libbey P. 2007. Exploring accreditation: striving for a consensus model. *J. Public Health Manag. Pract*. 13(4):334–36
3. Brewer R, Joly B, Mason M, Tews D, Thielen L. 2007. Lessons learned from the multistate learning collaborative. *J. Public Health Manag. Pract*. 13(4):388–94
4. Corso L, Landrum LB, Lenaway D, Brooks R, Halverson P. 2007. Building a bridge to accreditation—the role of the National Public Health Performance Standards Program. *J. Public Health Manag. Pract*. 13(4):374–77
5. Explor. Accred. 2007. *Frequently asked questions*. **http://www. exploringaccreditation.org**
6. Explor. Accred. Plan. Comm. 2006–2007. *Final recommendations for a voluntary national accreditation program for state and local public health departments: full report, winter 2006–2007*. **http://www.exploringaccreditation.org/Documents/FullReport.pdf**
7. Inst. Med. 2003. *The Future of the Public's Health in the 21st Century*. Washington, DC: Natl. Acad. Press
8. Inst. Med. Comm. Study Fut. Public Health. 1988. *The Future of Public Health*. Washington, DC: Natl. Acad. Press
9. Joly B, Polyak G, Davis MV, Brewster J, Tremain B, et al. 2007. Linking accreditation and public health outcomes: a logic model approach. *J. Public Health Manag. Pract*. 13(4):349–56

10. Kohn LT, Corrigan JM, Donaldson MS, eds, Inst. Med. 2000. *To Err is Human: Building a Safer Health System*. Washington, DC: Natl. Acad. Press
11. Lenaway D, Halverson P, Sotnikov S, Tilson H, Corso L, Millington W. 2006. Public health systems research: setting a national agenda. *Am. J. Public Health* 96(3):410–13
12. Lenihan P, Welter C, Chang C, Gorenflo G. 2007. The operational definition of a functional local public health agency: the next strategic step in the quest for identity and relevance. *J. Public Health Manag. Pract*. 13(4):357–63
13. Mays G, Claxton G, White J. 2004. Managed care rebound? Recent changes in health plans' cost containment strategies. **http://www. healthaffairs.org/RWJ/Mays.pdf**
14. Public Health Found. 2007. *Report of the faculty-agency forum, now continuing as the Council on Linkages.* **http://www.phf.org**
15. Public Health Funct. Steer. Comm. 1997. *Public health in America*. **http://www.health.gov/phfunctions/public.htm**
16. Turnock B, Barnes P. 2007. History will be kind. *J. Public Health Manag. Pract*. 13(4):337–41

Hugh H. Tilson
Chapel Hill, North Carolina