



**From Theory to Practice: Local Health Department
Accreditation Preparedness Efforts in Beautiful Lake
Cumberland Kentucky**

By:

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Accreditation may be defined as “The periodic issuance of credentials or endorsements to organizations that meet a specified set of performance standards.”¹

Kentucky Health Department Organization, Funding and Quality Assurance

Organization

Each of Kentucky’s 120 counties has a local health department (LHD). The LHDs are arranged as 56 “sovereign agencies” in that they are governed by Local Health Boards or their functional equivalent. In Kentucky, health boards can remain single county Boards of Health; or multiple counties can join to form District Boards of Health. Seventy-nine counties are governed by District Boards of Health and 41 by single County Health Boards (Kentucky Department for Public Health Website).² The Lake Cumberland District Health Department is governed by the largest District Board of Health in the Commonwealth with ten member counties: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne.

Funding

The lion’s share of LHD funding comes from three sources: 1) local tax revenues, 2) third-party billings and 3) state and federal grant funds. The smallest of these funding sources comes from local tax monies. Generally speaking, the health boards in Kentucky also serve as special taxing districts that levy a “local public health tax”.

The health departments can also bill third-party payers (Medicaid, predominately) for a variety of preventative and other services. Generally speaking, this is the largest funding source for LHDs. The remaining funding comes from state and federal grants

¹ Novick, Lloyd, Mays, Glen, Morrow, Cynthia, “Public Health Administration: Principles for Population-based Management”, 2nd Edition, Jones and Bartlett, 2007.

² <http://chfs.ky.gov/NR/rdonlyres/BDB27CBC-FA60-4FF5-8595-2D104AD6D162/0/KentuckyHDDistrictsCounties.pdf>

that predominately flow through the Kentucky State Department for Public Health (DPH): in essence, the LHDs act as sub-contractors for the DPH to implement the various state and federal grant programs.

Quality Assurance/Oversight

Local Health Departments implement a plethora of different state or federal programs – and, to a limited degree, local programs. Each state and federal program has its own unique set of rules and requirements with which the LHDs are expected to comply. The DPH completes occasional LHD site reviews of many of these various programs. Further, some of the LHDs have developed and implemented several internal quality improvement functions that might include periodic chart and billing review and patient satisfaction surveys. For the purposes of this paper, the question arises, “As far as quality assurance is concerned, is this all that is needed or is something more, such as accreditation, needed as well?”

The Seeds of Local Health Department Accreditation: A Common Framework

In its 1988 book, “The Future of Public Health”, the Institute of Medicine stated:

Many of the major improvements in the health of the American people have been accomplished through public health measures. Control of epidemic diseases, safe food and water, and maternal and child health services are only a few of the public health achievements that have prevented countless deaths and improved the quality of American life (“The Future of Public Health”, Executive Summary, pg. 1).³

However, the book also went on to say:

...public health is currently in disarray. Some of the frequently heard criticisms of public health are deserved, but this society has contributed to the disarray by lack of clarity and agreement about the mission of public health, the role of government, and the specific means necessary to accomplish public health objectives. (“The Future of Public Health”, Executive Summary, pgs. 6-7).⁴

Twenty years after the publishing of that book, what can be said about public health in Kentucky? While we in the Commonwealth are proud of the accomplishments of public health, we also still acknowledge the “lack of clarity”. A fond saying of the LHD Directors is, “If you have seen one LHD you have seen one LHD”. The emphasis being that each health department organization’s services are governed, administered and

³ Committee for the Study of the Future of Public Health; Division of Health Care Services, “The Future of Public Health”, The National Academies Press, 1988. Executive Summary On-line at: http://www.nap.edu/nap-cgi/execsumm.cgi?record_id=1091. Full text On-line at: http://www.nap.edu/nap-cgi/execsumm.cgi?record_id=1091.

⁴ *ibid*

delivered in a somewhat unique manner. To add to this complexity I pose the question, “Do the programs we deliver result in positive public health outcomes?” If the other Health Department Directors are like this writer, we “deliver” the programs approved by the Kentucky State DPH with a blind faith that if we do so in an efficient, serious and thoughtful manner – albeit somewhat differently from health department to health department – positive health outcomes will be the natural product. This may or may not be the case since tying public health outcomes back to specific health departments and specific programs is difficult and often not even attempted. Setting aside this critique and assuming that LHD programmatic successes and failures are measured, in a delivery system as varied as the LHDs, how can the causalities of public health programmatic successes or failures be ascertained since each health department delivers such in a somewhat unique fashion?

To clarify this point, allow me to indulge you in a theoretical example. To combat the growing epidemic of obesity and the devastating health consequences of smoking cigarettes, the LHDs might choose to implement a certain nutrition/non-smoking program – “Fruitine and Nictables: Get Addicted to Good Health” (a factious program – for illustrative purposes only – that imagines nicotine enhanced fruit and vegetables). Five years after the implementation of this much touted program there are no overall statistically measurable improvements in the reduction of the instances of obesity or those who smoke. So, was this “dynamic and creative program” at fault in that it was an ill conceived and poorly researched endeavor to begin with; or is the statistical outcomes failure due to a systemic problem? If every health department implemented said program in a somewhat unique manner – some putting significant amounts of time, money, effort and planning into the delivery of such, while others only made superficial commitments – then how can anyone sort out if the failure to generate positive health outcomes were a result of a programmatic failure versus a failure in the varied LHD service delivery system?

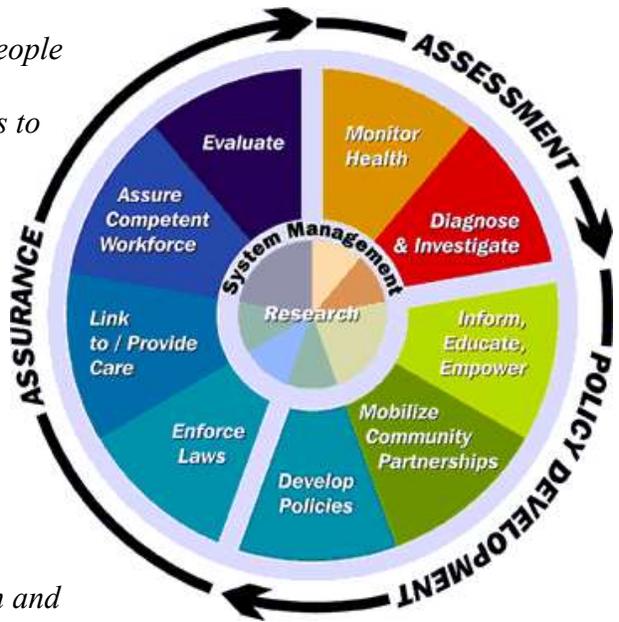
Therefore, was the Institute of Medicine correct in its book, “The Future of Public Health”, when it suggested that the answers to such conundrums lie in: 1) a commonly agreed upon mission, 2) commonly agreed upon governmental roles and 3) commonly agreed upon “means” to accomplish objectives? Would a common mission, roles and “means” establish a standard framework through which health department activities could be viewed and measured and, in essence, provide a standard “yard stick”? Would this create the consistency of service delivery so that programmatic successes or failures could more easily and readily be ascertained? If so, what should the mission of public health be, what should the health board and health department’s roles be, and what “means” should be utilized to accomplish public health objectives?

For the purposes of this paper, the establishment of a specific common mission will be set aside. As far as roles and “means”, “The Future of Public Health”, laid a foundation for such when it identified three core functions of public health: 1) assessment, 2) policy development, and 3) assurance (Executive Summary, pg. 8)⁵.

⁵ *ibid*

Building upon this foundation, in 1993 the U.S. Public Health Service convened a national workgroup, The Public Health Functions Steering Committee. This committee was chaired by the Surgeon General and attempted to provide a more descriptive theoretical framework for public health. In the fall of 1994, the committee produced, “Public Health in America”, which first expanded the three core functions of public health into the “Ten Essential Services of Public Health”. These “Ten Essential Services” include:

1. *Monitor health status to identify community health problems.*
2. *Diagnose and investigate health problems and health hazards in the community.*
3. *Inform, educate, and empower people about health issues.*
4. *Mobilize community partnerships to identify and solve health problems.*
5. *Develop policies and plans that support individual and community health efforts.*
6. *Enforce laws and regulations that protect health and ensure safety.*
7. *Link people to needed personal health services and assure the provision of health care when otherwise unavailable.*
8. *Assure a competent public health and personal health care workforce.*
9. *Evaluate effectiveness, accessibility, and quality of personal and population-based health services.*
10. *Research for new insights and innovative solutions to health problems (Answers.com).⁶*



From this writer’s perspective, there have been two major efforts to expound upon the theoretical framework of the “Ten Essential Services”: 1) the National Association of City and County Health Official’s (NACCHO’s) “Operational Definitions of a Functional Local Health Department”⁷, and 2) the Centers for Disease Control’s (CDC’s): “National Public Health Performance Standards Program (NPHPSP)”⁸;

6 <http://www.answers.com/topic/essential-public-health-services?cat=health>

7 <http://www.naccho.org/topics/infrastructure/accreditation/operationaldefinition.cfm>

8 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, “National Public Health Performance Standards Program: State Public Health System Performance Assessment Instrument, Version 2.0”. Full text On-line at: <http://www.cdc.gov/od/ocphp/nphpsp/NewInstrument.htm>.

Between these two, the one most directly related to the *overall* functions of an LHD is NACCHO's "Operational Definitions" (NACCHO.org)⁹. These "Operational Definitions" begin to bridge the gap between the theoretical framework of the "Ten Essential Services" and the reality of day-to-day LHD functions. The "Operational Definitions",

...assume...that there are roles that the local public health agency cannot delegate or assume that others will perform. It uses the Ten Essential Services to frame the activities that show how a local public health agency fulfills its governmental role (Thielen, pg. 12)¹⁰.

To illustrate how the "Operational Definitions" expound upon the theoretical framework of the "Ten Essential Services", the following example is included. This particular "Operational Definition" restates "Essential Service One" as follows and adds the subsequent standards:

- 1) Monitor health status and understand health issues facing the community.*
 - a. Obtain and maintain data that provide information on the community's health (e.g., provider immunization rates; hospital discharge data; environmental health hazard, risk, and exposure data; community-specific data; number of uninsured; and indicators of health disparities such as high levels of poverty, lack of affordable housing, limited or no access to transportation, etc.).*
 - b. Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.*
 - c. Conduct or contribute expertise to periodic community health assessments.*
 - d. Integrate data with health assessment and data collection efforts conducted by others in the public health system.*
 - e. Analyze data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public's health.*

To go an additional step still, several states have developed LHD accreditation systems that build and farther expound upon NACCHO's "Operational Definitions". These models have "standards and benchmarks" which, in effect, delineate *specifically* what LHDs should do in their efforts to aspire toward the expectations of the "Operational Definitions". In this writer's opinion, this type of model would be the best for Kentucky. In fact, in the document, "Final Recommendations for a Voluntary National Accreditation Program" --

⁹ *ibid*

¹⁰ Thielen, Lee, Robert Wood Johnson Foundation, "Exploring Public Health Experience with Standards and Accreditation: Is it Time to Stop Talking About How Every Health Department is Unique?", October 2004.

The Difference Between the Modern Concept of “Public Health” and Local Health Department Accreditation

Most contemporary public health research rightly describes public health as being accomplished either directly or indirectly by many different “units” within the local community, state and nation. In its 1988 book, *The Future of Public Health*, the Institute of Medicine defined public health as, “...what we, as a *society, do collectively* to assure the conditions in which people can be healthy” (Executive Summary, pg. 1)¹³. Notice the emphasis on “society” (or what might be deemed as the entire “public health system”) and not just on what LHDs do. In 2003, the Institute of Medicine (IOM) published a report entitled “The Future of the Public’s Health in the 21st Century”¹⁴ which suggested several areas for action and change to strengthen the “public health system”.

From a local perspective, this “public health system”, as illustrated above, is conceived as all local entities that provide direct and in-direct public health services such as hospitals, schools, social services, mental health, home health, park services etc. Though this view of “public health” is technically accurate, it creates a hurdle in regard to LHD accreditation since neither the LHD nor, for that matter, any other single entity is in control of the entire “public health system”. Therefore, no single entity can feasibly “assure” that the entire “public health system” is actively striving toward improved public health goals and/or improvements in the “public health system”. In this world of shrinking resources, the entities contained within the “public health system”, in reality, struggle to achieve their own specific primary missions and have few if any surplus financial or human resources to devote to “public health” endeavors.

So, what part should the LHD play within the “public health system” and how should this tie to LHD accreditation? From this writer’s perspective, LHDs should take a lead role in “Essential Service Four” and strive to mobilize community partnerships to identify and solve health problems. However, in reality, this is just one part of what an LHD does and a role for which it generally receives limited or no funding. Considering the lack of funding for such and the absence of LHD authority over the other units within the “public health system” an LHD accreditation model should only place a measured degree of emphasis on such.

North Carolina’s (NC) LHD accreditation model seems to achieve the right balance in this regard. According to the NC Health Department Accreditation Board:

The focus of North Carolina’s Local Health Department Accreditation ...is on the capacity of the Local Health Department to perform at a prescribed, basic level of quality the three core functions of assessment, assurance, and policy development and the ten essential services... The program focuses on a set of minimal standards that must be provided to

¹³ *ibid*

¹⁴ Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion and Disease Prevention, Institute of Medicine of the National Academies, “The Future of the Public’s Health in the 21st Century”, The National Academies Press, 2003.

ensure the protection of the health of the public, but does not limit the services or activities an agency may provide to address specific local needs. (North Carolina Local Health Department Accreditation Board Website).¹⁵

Analyzing the above quote from the NC accreditation website, two things can be gleaned. Their accreditation model strives to measure: 1) the capacity of LHDs to perform at prescribed levels, and 2) the accomplishment of minimal standards that ensure the protection of the health of the public. Understanding that NC's model's "benchmarks and standards" are expansions of NACCHO's "Operational Definitions of a Functional Local Health Department" and understanding that its primary emphases is on the LHD and not the entire "public health system" makes it a preferable LHD accreditation model and one in which, from this writer's perspective, should be used as a model for Kentucky.

How Can Accreditation Effect Positive Health Outcomes?

The goal of accreditation should ultimately be to affect positive public health improvements. However, research evaluating the link between improved public health outcomes and accreditation provides little evidence of such. In the article, "Accreditation of Public Health Agencies: Is Arkansas Ready?", the author records:

*With the increased emphasis on outcomes, performance measures, and standardizing public health practice, there is a need to look to the research for guidance on the adoption of these methods. There is, however, a lack of evidence that links performance standards and accreditation programs to population and community health improvement (Ridgeway, pg. 6).*¹⁶

Therefore, if not direct community health improvements then what can accreditation models offer LHDs? As stated earlier, accreditation models can help to ensure more consistent standards and methods are being utilized by all the LHDs. This "common framework" should make it easier to measure overall programmatic successes and failures that, in turn, should ultimately better direct LHDs toward programs that demonstrate positive public health outcomes.

To elaborate upon this concept, I would argue that, in order for a LHD to affect statistically significant health changes in its community, three things must happen: 1) the LHD has to be ran well in general having good, well-trained management and staff that are working in an enthusiastic manner that meets minimal standards, 2) the LHD has to be providing evidenced-based programs that have been well enough designed, conceived and researched in the first place as to render positive health outcomes providing they are delivered in a substantial, serious, and thoughtful manner, and 3) the LHD must put enough planning, time, energy and finances into a particular program and deliver it broadly enough into the target population and for a long enough duration of time. It is

¹⁵ <http://nciph.sph.unc.edu/accred/index.htm>

¹⁶ *ibid*

entirely possible to have a great staff and organization that is putting much time, energy and resources into a particular program; but, if that program simply doesn't work, then the LHD's efforts will prove unfruitful. Furthermore, if an LHD uses poorly trained and motivated staff, it doesn't matter how good the program utilized is, it will fail in generating positive results. Finally, if a LHD uses well-trained and motivated staff to deliver a proven program but doesn't implement the program in such a way that its delivery penetrates deeply enough into the target population or if the program is offered for too short of a duration of time, then an improvement in the community's health status will likely fail to occur.

From this writer's perspective, an LHD accreditation model can feasibly assure that the LHD as a vehicle of service delivery is mechanically sound and appropriately fine tuned and meeting minimum standards. In fact, "Several studies...suggest that accreditation programs have had positive effects on the operations of organizations undergoing accreditation" (Mays, 2004)¹⁷ Therefore, accreditation can feasibly address item one as noted above and ensure compliance with standards and benchmarks that ideally have been developed from NACCHO's "Operational Definitions". Remember, that NACCHO's "Operational Definitions of a Function Local Health Department",

"...assumes that there are roles that the local public health agency cannot delegate or assume that others will perform. It uses the Ten Essential Services to frame the activities that show how a local public health agency fulfills its governmental role" (Thielen, pg. 12)¹⁸.

From this writer's perspective, LHD accreditation can not feasibly address items two or three as noted above. Only a State DPH accreditation effort can achieve these goals. Only the State DPH can oversee that LHDs across the entire Commonwealth are, in a consistent manner, investing minimal amounts of time and resources into the various grant funded programs. Once this is accomplished, the State DPH is the only entity in a position to implement serious statewide programmatic outcomes evaluations. Therefore, before any LHD accreditation process can ultimately generate positive public health outcomes, a State DPH accreditation model should be concurrently developed. In fact, the "Final Recommendations for a Voluntary National Accreditation Program", assumes that co-occurring State DPH and LHD accreditation models should be developed.

Barriers to LHD Accreditation

A review of available research suggests that the single largest barrier to LHD accreditation is the cost. In his 2004 paper, "Can Accreditation Work in Public Health? Lessons From Other Service Industries: Working Paper Prepared for the Robert Wood Johnson Foundation", May's eloquently identified this concern as follows:

¹⁷ Mays, Glen P., Ph.D., M.P.H., Department of Health Policy and Management, College of Public Health, University of Arkansas for Medical Sciences, "Can Accreditation Work in Public Health? Lessons From Other Service Industries: Working Paper Prepared for the Robert Wood Johnson Foundation", November 30, 2004.

¹⁸ *ibid.*

Accreditation programs entail significant costs that must be weighed against the potential benefits to determine feasibility and value. Available evidence suggests that application and survey fees are only a small part of the costs incurred by service providers undergoing accreditation. The vast majority of costs are incurred in preparing for accreditation surveys and site visits and providing relevant staff training. (pg. 25)¹⁹

Additionally, while perhaps not a barrier but at least a concern to state efforts to develop their own accreditation models is the chance that such won't be recognized by the National Public Health Accreditation Board that plans to roll out a voluntary nationwide public health accreditation model in 2011. In the report, "Final Recommendations for a Voluntary National Accreditation Program", it is stated that:

A national program should complement state-based efforts to establish performance standards for public health departments. This may be accomplished by a recognition/approval process through which state accreditation programs could demonstrate conformity with national accreditation standards and processes. (pg. 9)²⁰

Hence, there is no guarantee that state accreditation models will be recognized by the National Public Health Accreditation Board. It is conceivable that federal funds could be tied to national accreditation and not state accreditation.

Conclusion/Recommendations

While I am not convinced that Kentucky should develop its own accreditation model instead of waiting for the national model, I do think Kentucky should take steps to prepare for the eventuality of LHD accreditation. I would recommend that any preparatory efforts be grounded in the "Operational Definitions of a Functional Local Health Department". Also, while positive public health outcomes haven't conclusively been tied to accreditation, "...studies... (do) suggest that accreditation programs have had positive effects on the operations of organizations undergoing accreditation." (Mays, 2004)²¹ Therefore any such preparatory efforts should yield positive organizational benefits.

¹⁹ *ibid*

²⁰ *ibid*

²¹ Mays, Glen P., Ph.D., M.P.H., Department of Health Policy and Management, College of Public Health, University of Arkansas for Medical Sciences, "Can Accreditation Work in Public Health? Lessons From Other Service Industries: Working Paper Prepared for the Robert Wood Johnson Foundation", November 30, 2004.