

Challenges, Opportunities, and Strategies for Rural Public Health Agencies Seeking Accreditation

*Michael Meit, MA, MPH, Karen Harris, MPH, Jessica Bushar,
Bhumika Piya, and Maria Molfino*

Public health systems in rural areas differ from those in urban areas in terms of scope of services and functions, in part due to differences in the level of resources available and in part based on geographic isolation and the corresponding size of the population served. How these distinctly rural features affect state-level public health governance, state support for local health departments (LHDs), and local health department functions, is not well understood. Many 'public health' functions are conducted, at least in part, by hospitals, private practice physicians, and community-based organizations, as well as a variety of entities that are not focused strictly on health. Moreover, many rural areas have no local governmental public health infrastructure at all. In these instances, the state health department (SHD) bears responsibility for the provision of local public health services, which are provided either directly through units of the state health department, or contracted to other local providers such as hospitals and non-governmental organizations.

The purpose of this study was to enhance understanding of how public health infrastructure may dictate rural health departments' approaches to seeking accreditation. Specifically,

KEY FINDINGS AND RECOMMENDATIONS Rural LHD Expert Panel

- Efforts to develop consistent standards present unique challenges for rural LHDs given the wide variance in rural public health infrastructure and services delivered in rural areas.
- Panelists felt that accreditation would improve credibility and bolster esteem for the role of public health—both in the community and among LHD staff.
- Panelists mentioned improving capacity and quality of services as key benefits of accreditation.
- To stimulate LHDs to pursue and complete accreditation, panelists suggested focusing on concrete results to be gained through accreditation, using innovative funding strategies to support accreditation activities, and creating tiered or phased systems (based on the specific services provided by LHDs, as opposed to requiring all LHDs to meet one rigid set of standards) as possible strategies.
- Inadequate funding and staff knowledge about accreditation were cited as the major barriers to accreditation.

Key Informant Interviews with State Officials

- SHD accreditation has been explored by all states represented in the analysis; the degree to which states have explored SHD accreditation varied, however.
- Most respondents mentioned funding as an incentive to seeking state health department accreditation; other incentives included quality improvement, national recognition, relationship building, and workforce recruitment.
- Respondents felt that states with direct responsibility for local jurisdictions should be held accountable to LHD accreditation standards.
- A multi-level approach to accreditation was suggested for states in which the state agency staff provides services to regions not covered by LHDs, focusing on: 1) local public health services; 2) state public health services; and 3) local public health services provided by the state.
- Respondents felt that accreditation efforts should consider contracted services, but not all states were certain that local contracting partners should be held accountable to LHD accreditation standards.
- Limited fiscal and human resources, leadership and legislative barriers were most often mentioned as obstacles associated with state agency accreditation.

Challenges, Opportunities, and Strategies for Rural Public Health Agencies Seeking Accreditation

NORC studied the perceived barriers and opportunities to public health agency accreditation among state and local health departments serving rural jurisdictions, and recommended strategies for moving forward. This research was comprised of three phases: 1) a literature review; 2) a half-day panel discussion with eleven representatives of LHDs located in rural areas; and 3) semi-structured, key informant interviews with eight representatives of SHDs with rural areas not served by local governmental public health.

METHODS

A literature review was conducted to provide background and context for the two research components of the study. The review provided a brief history of accreditation efforts, current trends, and the documented experiences of health departments in pursuing accreditation. Wherever possible, literature that included rural health departments was referenced. Where there were gaps in knowledge, hospital and health plan accreditation studies that included rural facilities were referenced, as findings may be at least somewhat generalizable to public health.

The panel discussion brought together eleven LHD representatives from rural areas to understand why LHDs serving rural areas may seek accreditation, how those agencies are likely to approach accreditation, and what they perceive as barriers to and strategies for accreditation. An open call for panelists and a pre-panel questionnaire were used to identify participants with diverse backgrounds in terms of their familiarity and direct experience with accreditation. Further, analyses were conducted using RUCA Codes¹ to

ensure a wide range in the degree of rurality among participants. NORC worked closely with the Centers for Disease Control and Prevention (CDC) and the National Network of Public Health Institutes (NNPHI) to develop structured protocols for the panel discussion.

Semi-structured interviews with current and former leaders from SHDs were conducted to identify strategies and challenges to ensuring access to public health services in communities not served by LHDs, and implications for state level accreditation. Using a preliminary list of states with commonly-defined centralized and mixed infrastructures, discussions were then held with CDC, NNPHI, and the Association of State and Territorial Health Officials (ASTHO) to select a final sampling frame based on knowledge of state public health systems in which at least some rural communities are not under the jurisdictional authority of an LHD or localized unit of the state health department. States ultimately included in the study were Maine, New Hampshire, New Mexico, Pennsylvania, South Dakota, Texas, Utah and Wyoming.

KEY FINDINGS – RURAL LHD EXPERT PANEL

Effect of Rurality on LHD Readiness to Pursue Accreditation – Most panelists stated that efforts to develop consistent standards present unique challenges for rural LHDs. They believe that rural health departments do not view accreditation as a priority, and their staff members have not bought into the concept of accreditation. Panelists felt that specific

characteristics (e.g., size, jurisdiction type, or population served) and organizational capacities (e.g., funding, resources, and staff training) influence whether an LHD is able to meet accreditation standards.

Rationale for Seeking Accreditation

– In discussing the benefits of accreditation, the recurrent themes were enhanced capacity and improved quality of services. A number of panelists also felt that accreditation would bolster esteem for public health, both in the community and among LHD staff. Some hoped that becoming accredited would better position LHDs to receive funding, while others were skeptical as to whether this would be an immediate benefit. Several thought that accreditation could foster collaboration among stakeholders in order to meet standards. The panel's discussion of incentives and motivations for seeking accreditation suggested that funding would be a critical incentive and motivator for embarking on the accreditation process. Other incentives mentioned by the panelists included: enhanced capacity and performance; and improved communication about the role, functions, and accomplishments of public health.

Barriers to Seeking Accreditation

– Local leaders cited inadequate staff knowledge about accreditation as a significant barrier. Yet, staff members at LHDs may not necessarily be receptive to additional training. Often, they are not formally trained in public health, and therefore may not fully understand its mission. Shortages of other resources, including funding to carry out accreditation activities, were also cited as problematic. Structural barriers mentioned include fragmented public health systems, siloed funding

¹ The Rural-Urban Commuting Area (RUCA) system is one of several ways to classify rural areas. RUCAs use the Census Bureau's definitions of Urbanized Areas and Urban Clusters combined with population work commuting information to characterize the rural and urban status of census tracts. The RUCA classification is, thus, based on the size and population density of cities and towns and their functional relationships as measured by work commuting flows. Categories describing degrees of rurality were defined as follows: RUCA codes 1-3 represent urban areas; and RUCA codes 4 and higher represent rural areas.

streams, a lack of credible data, and decision-makers who are not well-informed about public health possibly perceiving accreditation as a potential cost to the county.

Strategies Rural LHDs May Use to Become Accredited

– Ideas for stimulating LHDs to pursue accreditation included focusing on concrete

outcomes from accreditation, using innovative funding strategies to support accreditation, and creating a tiered or phased accreditation system. The concept of “tiering” focused on developing a process that would allow limited service LHDs to be accredited for the services they provide (i.e., offering different levels of accreditation that would allow LHDs to build capacity over time). Panelists also emphasized convening trainings and educational efforts for staff and local decision-makers such as county commissioners and boards of health. Finally, panelists suggested maximizing the use of existing resources by forming partnerships with academic institutions and community based-organizations.

Engaging National, State, and Regional Partners to Pursue Accreditation

– The panelists suggested that LHDs could come together through regional partnerships to ensure the provision of core services and thereby achieve accreditation standards. In the discussions, regionalization was conceptualized in two different ways: (1) as the establishment of a regionalized public health agency across multiple jurisdictions; and (2) as a formalized collaboration between multiple, independent public health agencies. Yet, despite the potential benefits of regionalized solutions, panelists saw some obstacles in this

approach. Most notably, partnering implies giving up a certain level of local control, which may not be welcomed by local decision makers. At the national level, panelists expressed the opinion that rural health departments are not adequately represented in national accreditation efforts; the degree to which rural LHDs are “at the table” at the state-level varies widely by state.

“Money drives the system. The current system does not value the ability to assess problems locally. So, if there is money to drive assessment, that will drive accreditation.”

– LHD panelist

Accountability and

Other Factors Driving Accreditation

– To be meaningful, panelists felt that accreditation should involve external, objective surveyors as opposed to peer-reviewers. Panelists also noted that while the potential to link accreditation to health outcome measurement may sound like a benefit, there is a risk that improved ability to track outcomes could show that public health efforts are not having the desired impact. Further, changes in health outcomes take a long time to emerge, so that short-term indicators should be

identified to provide evidence of progress toward outcomes. Commenting that funding streams drive LHD priorities, a

panelist noted that, “if resources were provided to support accreditation, LHDs would embrace it wholeheartedly.”

“We fancy ourselves as leaders, early adopters and innovators. Accreditation will allow us to demonstrate this to the community. Regionally, this may help us show we are better than other health departments and push us to compete with our peer groups.”

– SHD panelist

in this analysis; the depth of this exploration varied, however. Some respondents noted that their state is actively exploring state level agency accreditation by participating in assessment activities and engaging key stakeholders, for example, while others mentioned informal accreditation discussions at the state level. Regionalization was mentioned by respondents as a possible strategy for streamlining public health services. All respondents noted that their respective states do not have an accreditation process in place for LHDs. Several states have explored the possibility of developing an LHD accreditation program; however, most respondents expressed uncertainty about whether their state would encourage LHD accreditation through a voluntary national accreditation system.

Incentives for SHD Accreditation

– Most respondents mentioned funding as an incentive to seeking SHD accreditation. Other incentives that were discussed include: improvement in the quality of health; national recognition; relationship building;

workforce recruitment; and educating elected officials and the community.

Barriers to SHD Accreditation

– Limited fiscal and human resources, leadership, and legislative barriers

were most often mentioned as obstacles associated with state agency accreditation. Several respondents mentioned that the specificity and rigor of accreditation standards may also be a challenge. A final barrier noted by respondents was that the accreditation of SHDs may have a limited impact on the community, making it hard to justify among policy makers and community members.

KEY FINDINGS – STATE LEVEL KEY INFORMANT INTERVIEWS

Exploration of State and Local Level Accreditation – SHD accreditation has been explored by all states represented

State Direct Provision of Public Health Services and Implications for Accreditation

– Most respondents reported that SHD staff assist in providing services to regions not covered by LHDs. A multi-level approach to accreditation was suggested for these states, focused on: 1) local public health services; 2) state public health services; and 3) local public health services provided by the state. Most respondents also felt that states with direct responsibility for local jurisdictions should be held accountable to LHD accreditation standards.

State Contracting of Public Health Services and Implications for Accreditation

– Respondents collectively confirmed that their states contract with local non-governmental partners to provide local public health services. Recommendations to incorporate contracted services into accreditation efforts included: quality improvement processes/assessments to monitor contracted services; educating contractors about local public health; and including local accreditation standards in contracts. In terms of accountability for services provided at the local level, respondents were less certain whether local contractors should be held accountable to LHD accreditation standards.

CONCLUSIONS

A number of salient themes emerged from the expert panel meeting and the state level interviews. First, efforts to develop consistent standards through accreditation present unique challenges for rural LHDs. Given the

lack of uniformity across public health agencies in general, and rural agencies specifically, the need to demonstrate consistency in public health services was seen as important to rural health departments. Both the state officials and LHD representatives agreed that because all agencies would be required to adhere to set standards, accreditation could lead to improved quality of services, while setting a bar for health departments to achieve certain capacities.

At both the state and local levels, most respondents mentioned funding as an important incentive to seeking accreditation. Other incentives included: quality and capacity improvement; state and national recognition; relationship building; workforce recruitment; and educating/informing the public, staff, elected officials, and other stakeholders about the importance of public health. Respondents suggested that accreditation could potentially be used as a tool to communicate the functions of public health by delineating its responsibilities and clarifying its role to the public. Limited fiscal and human resources were identified as major barriers associated with accreditation. In addition, respondents identified leadership, legislative barriers, and the rigor of accreditation standards as other potential challenges. Perceptions related to cost and limited impact on the community may also make it hard to justify accreditation

among decision-makers and community members. Local level respondents also identified inadequate staff knowledge about accreditation and structural issues (fragmented public health systems) as key barriers.

Both the state and local level respondents mentioned regionalization as a strategy for creating a “critical mass” of services that can be efficiently delivered across sparse populations to meet standards. Both also mentioned the inclusion of public health partners – at the state level partners consisted of other state agencies; at the local level partners included community based organizations and health care delivery systems. The state and local level respondents also talked about using a tiered approach. While “tiering” at the local level was focused on developing a process that would allow limited service LHDs to be accredited for the services they provide, at the state level it was conceptualized as a “multi-level approach” focused on levels of public health service delivery such as centralized/program management functions, delivery of local services to areas without local governmental PH infrastructure, etc. Finally, both state and local participants believed that it would be important to conduct training and education for staff members, as well as state and local decision-makers in order to generate needed support.

“Trying to explain local public health is difficult. If you have national standards that you can use to show others, then they will get it.”

– SHD panelist

This project was conducted under contract to the National Network of Public Health Institutes (NNPHI), with funding from the Centers for Disease Control and Prevention. The conclusions and opinions expressed in this paper are the authors’ alone; no endorsement by NORC, CDC, NNPHI, or other sources of information is intended or should be inferred. The Walsh Center for Rural Health Analysis is part of the Department of Health Policy and Evaluation at NORC at the University of Chicago. For more information about this project or the Walsh Center and its publications, please contact Michael Meit at (301) 634-9324 or meit-michael@norc.org.