NOTICE OF REGULAR MEETING
OF THE WEBER-MORGAN HEALTH DEPARTMENT

Notice is hereby given that the Weber-Morgan Board of Health will hold its regularly scheduled meeting at the Weber-Morgan Health Department **Annex Building**, 455 23rd St, 2nd Floor Auditorium, Ogden, Utah commencing at **4:00 p.m.** on **Monday, September 22, 2025.**

Agenda for the meeting will consist of the following:

Welcome (Roll Call)	Angela Choberka

Action Items	
1) Approval of August 2025 Meeting Minutes	Angela Choberka
2) Emission Regulation	Sherrie Waters/Scott Braeden
3) Seager Clinic Funding Request	Brian Cowan
4) Accreditation	Sean Hansen
5) Approval of 2025/2026 Budget	Adriana Pruitt/Michela Harris

Information Items	
6) Director Report	Brian Cowan
7) Chair's Message	Angela Choberka
8) Adjourn	

In compliance with the Americans with Disabilities Act, individuals needing auxiliary Communication aids or other services for this meeting should contact Elvira Odeh at eodeh@webercountyutah.gov giving at least three days' notice.
Dated this 19th August 2025.

Weber-Morgan Board of Health
Minutes of Meeting
August 25, 2025

The Weber-Morgan Board of Health held its regular meeting on August 25, 2025, in the Health Department Annex at 455 23rd Street. The meeting was called to order at 4:00 p.m. with Angela Choberka presiding.

BOARD MEMBERS PRESENT:

Angela Choberka	Ken Johnson	Tiffany Bears- Virtual
Cheryle Allen	Neal Berube	Ali Martinez- Virtual
Bonnie Wahlen	Kevin Eastman	
Frank Brown	Gina Butters	

BOARD MEMBERS ABSENT:

Vaughn Nickerson
Lee Schussman

STAFF MEMBERS PRESENT:

Brian Cowan	Michela Harris	Bryce Sherwood	Kallie Kinghorn
Scott Braeden	Ryan Klinge	Lori Buttars	Lekelsi Talbot
Amy Carter	Cami Sullenger	Sherrie Waters	
Adriana Pruitt	Gage Jacobson	Summer Day	

OTHERS PRESENT:

Welcome and Introductions – Angela Choberka

Angela Choberka calls the meeting to order at 4:00 p.m. and welcomes those in attendance.

Approval of Board of Health Minutes of June 23, 2025. Motion Passes

A **MOTION** is made by Ken Johnson and **SECONDED** by Cheryle Allen to approve the minutes as written. The **MOTION** passes unanimously.

Employee Introduction Information Only

Brian Cowan introduces Kalli Kinghorn, a new employee at the Weber-Morgan Health Department, who comes from Weber State University to work in the Clinical Nursing division.

Financial Report Information Only

Adriana Pruitt introduces herself and explains her role as lead accountant for the Weber-Morgan Health Department, working in billing federal and state grants and on the county's budget. Adriana Pruitt presents the financial report detailing the year-to-date revenue and expenses for the third quarter. She explained the key budget columns: revised budget, year-to-date actuals, and percentage used currently around 62%, aligning with the year's progress. Adriana states that a major factor not aligning the numbers is that tax revenue is received at year-end, so the current tax income shows only 7%, making it show as if they're running a deficit. Adriana gives a few updates,

including a budget adjustment, added WIC OA funds. This helped in converting a part-time peer counselor to a full-time one. Also, an upcoming grant of $150,000, previously expected from tax revenue, will now fully fund some salaries, improving the revenue outlook. Due to staffing turnover, only 54% of the salary budget has been used. The department may request to use some of those savings later in the year. The proposed 2026 county budget is in progress, and the directors are also estimating the 2025 year-end. Ken Johnson asks about potential positions being kept and the impact of the budget. Brian Cowan states that due to instability and delays in federal funding, the Health Department has been cautious with spending to avoid overcommitting, and about 44% of the department's budget comes from federal grants or contracts, primarily through the state of Utah or direct federal sources. Brian states that this year, there have been key issues, including delays in grants, receiving partial grants, typically 70–75% with a promise of the remaining funds to be received later, instead of full amounts upfront. Some previously available grants are no longer offered, requiring the department to explore new funding opportunities, and making it difficult to plan and budget. Brian Cowan states the department is downsizing gradually by vacant positions not being refilled, rather than layoffs. These funding challenges are influencing how the 2026 budget is being developed and will impact how the department operates moving forward.

Emission Regulation **Action Item**

Brian Cowan introduces the emission regulation and explains that officials note that 1996 and newer vehicles can be tested using modern, affordable technology that the county already has. However, for 1995 and older vehicles, the necessary equipment is outdated, expensive to maintain, and no longer used. Brian states that given the declining number of older vehicles, the limited environmental impact, and the rising cost of maintaining the older testing equipment for tailpipe, a cost-benefit analysis shows the program is no longer effective for these vehicles. As a result, Weber and other counties across the Wasatch Front are considering phasing out emissions testing for 1995 and older vehicles. The timing is seen as appropriate, and Sherry Waters, the Emissions Program Manager, will provide more details. Brian Cowan proceeds to introduce Sherrie Waters, who is the Emissions Program manager. Sherrie Waters introduces their team and explains that tailpipe emissions testing is being phased out due to high costs and national EPA trends. Their agency has updated regulations to exempt vehicles from 1995 and older, while requiring onboard diagnostic (OBD) tests for 1996 and newer vehicles. They request the review of the updated regulation and plan to open it for public comment. Other counties are also making similar changes, and the EPA is reviewing all related regulations. A **MOTION** is made by **Ken Johnson** and **SECONDED** by **Gina Butters** to take the Emissions regulation to a public hearing and appointed Sherrie Waters as Hearing Officer. The **MOTION** passes unanimously.

Measles Update **Information Only**

Amy Carter gives an update following a June presentation on measles and immunizations, highlighting recent developments and actions taken by the Weber-Morgan Health Department. Amy states that National and State cases rose from 1,200 in June to 1,375 by August 20, expanding from 36 to 42 jurisdictions. Utah now has 13 confirmed cases, 7 in Utah County and 6 in Southwest Utah. The Southwest outbreak is linked to low vaccination communities near the Utah-Arizona border and is expected to grow. All 13 Utah cases were unvaccinated; most (9) were adults. Four public exposure

sites have been identified, with only one currently under monitoring. Amy continues that wastewater surveillance has detected measles in areas with known cases. In March 2025 measles response began. MMR vaccine uptake in Utah has increased 40%, with some areas seeing up to 100% increases, especially among toddlers and kindergarten-aged children. The Weber-Morgan area has seen a 50–60% increase. On August 13, the health department held a virtual training with school districts, charter, and private schools. The session reviewed case trends, immunization requirements, the 2019 Board of Health regulation for staff vaccinations, and outbreak preparedness. Amy states that each school has been assigned a health department nurse for support and outbreak response. Also, Resources include FAQs, letters for parents, checklists, and templates (in English and Spanish) to help schools address exemptions, educate families, and respond to suspected cases. A data-sharing agreement has been drafted to streamline communication during outbreaks, and some schools have already signed it. Ongoing communication and weekly check-ins with schools are planned. Amy states that Measles cases are rising, especially in unvaccinated populations, but local efforts in surveillance, vaccination, and school preparedness are actively addressing the situation. Amy is encouraging continued awareness, collaboration, and prevention through vaccination.

Director's Report **Information Only**

Brian Cowan Informs the board to look for an email coming this week with a link to complete the *Utah Open and Public Meetings Act* training, which takes about 15 minutes and is tracked by the State Auditor's Office. Also, a Budget Discussion for Public Health Accreditation. Next month's agenda will include a decision on whether to fund public health accreditation for 2026. Cost: $29,800 in 2026, then $8,400 annually afterward. The department is 94% ready to begin the accreditation process; some documents need updating. Brian Members will receive supporting materials, including articles from the *Journal of Public Health Management and Practice*, outlining the benefits of accreditation. Brian Cowan mentions International Overdose Awareness Day, August 31, and invites the board to an Event on Sunday, August 31, 7–9 PM at the Ogden Botanical Garden. This includes a ceremony, moment of silence, and the unveiling of the "Path of Hope," a community project honoring lives lost to overdose. Brian Cowan mentions collaboration among several local organizations, including the Weber-Morgan Health Department, USU Extension, and others. Brian Cowan states that nine "Purple Champions" will be recognized for their efforts in preventing overdose deaths.

Chair's Report- Angela Choberka **Information Only**

Angela Choberka expressed appreciation and admiration for the Weber-Morgan Health Department's involvement in a leadership program held in partnership with the Utah Public Health Association at Intermountain Health. They noted being impressed to see representatives from the department participating and highlighted the value of their engagement in professional development and leadership efforts.

The Annual Meeting adjourns at 4:52 p.m.

The next meeting will be held on September 22, 2025.

This language was posted on the public notice website, in the Standard Examiner and on our website:

A public hearing will be held to afford interested persons an opportunity to submit written data, views, and comments regarding proposed changes to the Motor Vehicle Inspection and Maintenance Program Regulation. Beginning in 2026, the EPA will no longer be giving emission reduction credits for tailpipe (TSI) testing, emissions testing software companies no longer have the demand or interest to maintain the equipment for tailpipe testing, and manufacturers are no longer producing the equipment needed. The proposed changes to the regulation include removing tailpipe (TSI) testing requirements for vehicles with a GVWR of 8500 lbs or less that are model year 1995 and older and vehicles with a GVWR OF 8501 – 14,000 lbs that are model year 1996-2007 powered by gasoline/CNG; removing station, technician and analyzer requirements for tailpipe testing including gas calibration, leak checks, and hang-up checks; removing EPA emissions cut point standards (appendix C); and removing adjustment procedures for vehicles that are model year 1981 and older that fail an emissions test (appendix G).

Copies of the proposed regulation are available for review at the Administration Offices of the Health Department located at 477 23rd Street, Ogden, Utah, or the Utah Public Notice Website. Interested persons can contact Sherrie Waters, Environmental Health Program Manager, at 801-399-7164 or swaters@webercountyutah.gov Written comments concerning the regulation will be considered as part of the hearing record if received at the Division office before 5:00 p.m. Friday, September 19, 2025.

A public hearing was held on Sept 10 from 5- 6 pm at our office for public comments. No one from the public attended and no comments were received. This specific timeframe was advertised on our website.

We received feedback from one gentleman via email. He is thrilled that his vehicle no longer needs an emissions test as he only drives it about 300 miles per year.

We will keep the public comment period open until Sept. 19 at 5 pm and report any additional comments that are received.

From: Waters, Sherrie
Sent: Tuesday, September 9, 2025 1:28 PM
To: 'Rick Hansen' <rhansenl@q.com>
Subject: RE: [EXTERNAL] How do I get the proposed regulations for truck emissions?

You're welcome Rick, thanks for your response!

From: Rick Hansen <rhansenl@q.com>
Sent: Monday, September 8, 2025 12:18 PM
To: Waters, Sherrie <swaters@webercountyutah.gov>
Subject: Re: [EXTERNAL] How do I get the proposed regulations for truck emissions?

Sherrie:

Thanks!
I happen to have a 1997 Chev K2500 that is affected by your proposal. It has an 8,600 GVWR. It will be nice to not have the emissions test. I really do not use it much at all. 300 to 500 miles a year hauling in the forest is about it.

Thanks again for both the proposal and your help for me to find it.

BTW I am all in favor of this proposal!

Rick Hansen

Board of Health – PHAB Accreditation and Pathways Information

What is Accreditation?

Accreditation is provided through the Public Health Accreditation Board (PHAB). This is a national accreditation program that assesses the health department's capacity to carry out Public Health services and best practices. It serves as both an accountability and transparency mechanism. The goal of PHAB is to help the department with the following

1. Promote a culture of quality and performance improvement
2. Increase capacity to respond to public health emergencies
3. Strengthening the health department's ability to serve the community
4. Assure stakeholders that the health department is delivering public health capabilities (surveillance, policy development, emergency preparedness, and communications, partnership development, performance management)

What is Pathways?

The Pathways Recognition Program offers health departments a way to make progress toward potential accreditation by still demonstrating best practices and foundational capabilities. The department would be required to complete 34 targeted measures, rather than the full 87 required for full accreditation.

PHAB's intention is that this program could be used by the department to eventually become fully accredited. To incentivize this, any measures completed through Pathways can be counted toward initial accreditation. Pathways is also a cohort-based program, meaning health departments participate as a group. It is divided into two tracks—Services and Partnerships, and Health Department Systems. The health department is prepared to complete both tracks simultaneously.

2026 Cost

Accreditation: $8,400	Pathways: $6,100
$500 off for completing the PHAB Readiness Assessment within a year	
Upload documents within 12 months of gaining access ($21,000 document review)	Upload documents within 6 months of gaining access
PHAB reviews documents and gives feedback within 6 months	
Annual fee $8,400 each year for 5 years + $12,000 Reaccreditation Review Fee on 5th year	If the health department applies for accreditation within 2 years after being pathways recognized, we will receive a $2,400 discount off accreditation fees ($1,200 off each of the first 2 years' Annual fees)

Where is the health department in the process?

- Completed PHAB Readiness Assessment on March 3rd, 2025
- PHAB recommends that we apply for Accreditation
- Accreditation progress = 96% complete
- Pathways progress (Track 1 = 97% complete, Track 2 = 100% complete)

Accredited Health Departments in Utah

- Utah Department of Health and Human Services - 2017 (Re-accredited 2022)
- Bear River Health Department - 2022
- Davis County Health Department – 2015 (Re-accredited 2020)
- Salt Lake City Health Department - 2014 (Re-accredited 2019)
- Tooele County Health Department – 2014 (Re-accredited 2019)

Next steps?

- A decision for the Health Department to go forward with Accreditation, Pathways, or neither option
- PHAB requires an approval letter from the Board of Health for either Accreditation or Pathways
- Weber-Morgan Health Department would begin the application process in January 2026 based on your decision. (application deadline is 2/5/2026)

Accredited Public Health Department Characteristics Associated With Workforce Gaps Identified in Workforce Development Plans

Ashlyn Burns, PhD, MPH; Haleigh Kampman, MPH; Harshada Karnik, PhD, MPP; Jonathon P. Leider, PhD; Valerie A. Yeager, DrPH, MPhil

ABSTRACT

Objective: When pursuing accreditation by the Public Health Accreditation Board, local health departments (LHDs) must submit a workforce development plan (WDP). The purpose of this study was to examine LHD characteristics associated with workforce gaps identified and strategies implemented by LHDs.

Design: We conducted a qualitative content analysis of all WDPs submitted to the Public Health Accreditation Board between March 2016 and November 2021.

Setting: We examined WDPs from all accredited LHDs (n = 183) at the time of data collection in January 2022. A majority of LHDs had more than 50 staff members (n = 106, 57.9%), had a decentralized governance structure (n = 164, 89.6%), had county-level jurisdictions (n = 99, 54.1%), and served rural populations (n = 146, 79.8%).

Main Outcome Measures: For each overarching theme, we constructed 2 binary variables indicating whether the LHD identified a workforce gap or strategy among any subthemes within each overarching theme. Logistic regressions were used to examine relationships between LHD characteristics and identification of a workforce gap or strategy for each theme.

Results: Few LHD characteristics were significantly associated with gaps identified or strategies implemented by LHDs. LHDs applying for reaccreditation had higher odds (adjusted odds ratio [AOR], 2.44; confidence interval [CI], 1.04-5.83) of identifying a leadership gap and of identifying a recruitment gap (AOR, 2.94; CI, 1.11-7.52) compared to LHDs applying for accreditation for the first time. LHDs serving urban populations had higher odds (AOR, 2.83; CI, 1.32-6.25) of identifying a recruitment strategy compared to LHDs that only served suburban/rural populations.

Conclusions: Overall, many workforce gaps reported by LHDs were universally observed irrespective of LHD characteristics. While most LHDs identified strategies to address gaps, our findings also reveal workforce areas where LHDs reported gaps without an accompanying strategy, indicating areas where LHDs could use more technical assistance and support.

KEY WORDS: accreditation, local public health, workforce development

Introduction

To strengthen public health infrastructure, the Public Health Accreditation Board (PHAB) began accrediting governmental public health departments (HDs) in 2011.[1] Accreditation is a voluntary process that established national standards for HD quality and performance.[1-5] When pursuing accreditation, HDs must submit a number of specific accreditation documents to PHAB, including a workforce development plan (WDP). Given that these documents contain rich insights about workforce gaps experienced by HDs and the strategies they are implementing to address them,[1,6] WDPs serve as a valuable source of information regarding the public health workforce.

Public health workforce challenges, such as personnel recruitment, retention, and training, have

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This study used a dataset generated by the Consortium for Workforce Research in Public Health (CWORPH), jointly funded by the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) for the Health Workforce Research Center Cooperative Agreement program under awards UR2HP47371 and U81HP47167. The content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by CDC, HRSA, HHS, or the US Government.

The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002046

been the focus of much of the recent public health systems and services research.[7-12] In fact, workforce shortages and employee intentions to leave the workforce draw attention to the crucial role of workforce development.[9-11] A number of recent initiatives and training programs have been put in place to support pathways to the workforce, eg, the Public Health AmeriCorps program, the Public Health Associates program, and other public health training programs offered by the Centers for Disease Control and Prevention.[13-15] However, the vast majority of studies that examine workforce development rely on self-reported employee-level data about training needs and training supports within HDs. The organizational perspective, detailed in documents such as WDPs, provides additional insight about what HD leaders are doing to develop, recruit, and retain employees. Only one previous study examined WDPs submitted as a required accreditation document.[6] Yeager et al conducted the first qualitative content analysis of WDPs to examine workforce gaps and strategies reported by HDs, which identified 8 workforce development themes.[6] Among these themes, the most common gaps identified by HDs were related to community engagement/partnerships and funding training needs.[6] Notably, HDs did not always identify a strategy to address the gaps they identified.[6] While we now have a better understanding of the most common types of workforce challenges reported by accredited HDs in their WDPs, we still know very little about how characteristics of HDs may be related to workforce challenges.

The purpose of the current study was to examine local health department (LHD) characteristics associated with workforce gaps using WDPs from all LHDs accredited under the 1.5 standards of the PHAB Standards & Measures or the 2016 reaccreditation Standards & Measures at the time of data collection. More specifically, we examined LHD characteristics associated with identifying a gap or a strategy across 8 overarching workforce themes commonly identified by LHDs in their WDPs. Additionally, we examined LHD characteristics associated with identifying specific strategies for addressing workforce gaps. Building on earlier work that summarized the types of workforce development gaps and strategies detailed in WDPs, this study provides further insight about the types of LHDs most likely to experience specific workforce challenges and to implement specific strategies. Accrediting bodies and policymakers may use this information to provide tailored guidance to strengthen workforce development.

Methods

Sample and design

This study was part of a larger qualitative content analysis of 201 WDPs submitted to PHAB between March 2016 and November 2021, representing all US LHDs accredited to date at the time of data collection in January 2022.

Coding framework

For complete details on our coding framework, structured training process, and data extraction procedures, please see the study by Yeager et al.[6] In brief, we utilized a coding framework with over 50 specific subthemes, each representing a workforce topic. A team of 11 coders indicated whether each subtheme was identified as a workforce gap in the WDP. The coding team also indicated whether a strategy for addressing each subtheme was identified. All subthemes were categorized into 8 overarching workforce development themes: (1) planning/coordination; (2) leadership; (3) organizational culture; (4) workplace supports/retention; (5) recruitment; (6) planning for departmental training; (7) delivery of departmental training; and (8) partnership/engagement.

Data and variables

The dependent variables examined in this study were derived from the workforce gaps and strategies identified through the qualitative coding of WDPs. To construct the dependent variables, we summed the respective subthemes for each of the overarching themes. We then converted each sum, representing the total number of gaps/strategies identified for each of the overarching themes, to a binary variable (yes/no) indicating whether any topic within a particular theme was identified as a gap in the WDP. In addition to the overarching themes, we also examined binary outcome variables representing the more common subthemes that LHDs identified strategies for, including: assessing staff satisfaction, offering tuition/loan repayment, establishing a learning/innovation culture, strengthening organizational inclusion/diversity/cultural sensitivity, engaging with colleges/universities, preparing the workforce for community engagement, implementing individual development plans, and providing a basic public health training for all staff.

Organizational characteristics of LHDs, provided by PHAB, served as our independent variables. Organizational characteristics available to us included the size of the population served

(small, medium, or large), accreditation type (initial or reaccredited), appointing authority (mayor, board of health, county commissioner, etc.), governance structure (decentralized, centralized, or shared), and jurisdiction (county, city, etc.). Given that LHDs often serve areas outside of the zip code they are located in, we also examined geographic regions served by the HD (rural, urban, and suburban) as reported to PHAB during the accreditation process.

Analysis

Descriptive statistics were tabulated to summarize the overall sample of accredited LHDs and frequencies of each workforce gap. Multivariate analyses using logistic regression models were used to examine the relationship between LHD characteristics and workforce gaps and strategies.

Results

Characteristics of the accredited HDs included in our analysis are presented in Table 1. Among the LHDs represented in our study, 24.6% (n = 45) were small (serving <50 000 people), 55.2% (n = 101) were medium size (serving 50 000-499 999), and the remaining 20.2% (n = 37) were large (serving 500 000+). The majority of LHDs were applying for initial accreditation (84.1%, n = 154), with 15.8% (n = 29) applying for reaccreditation. Appointing authorities included boards of health (30.1%, n = 55), county commissioners (14.2%, n = 26), mayors (8.2%, n = 15), directors of public health umbrella agencies (7.1%, n = 13), and other (40.4%, n = 74). LHDs were primarily in states with a decentralized or shared governance structure (98.4%, n = 180), with 1.6% (n = 3) in a centralized governance structure. Jurisdictions of HDs included county (54.1%, n = 99), city-county (19.7%, n = 36), district (13.7%, n = 25), city (10.4%, n = 19), town (1.1%, n = 2), regional/multijurisdictional (1.1%, n = 2). LHDs served rural (79.8%, n = 146), urban (48.1%, n = 88), and suburban (44.8%, n = 82) communities (nonexclusive categories representing all regions served by the LHD).

Table 2 presents findings from multivariate analyses examining organizational characteristics associated with identifying a workforce gap within each of the 8 overarching themes. LHDs applying for reaccreditation had higher odds (adjusted odds ratio [AOR], 2.44; confidence interval [CI]: 1.04-5.83) of identifying a leadership gap compared to LHDs applying for accreditation for the first time. LHDs applying for reaccreditation also had higher odds (AOR, 2.94; CI, 1.11-7.52) of identifying a recruitment gap. Findings from multivariate analyses examining organizational characteristics associated with having a workforce strategy identified within each of the 8 overarching themes are presented in Table 3. LHDs serving urban populations had higher odds (AOR, 2.83; CI, 1.32-6.25) of identifying a recruitment strategy compared to LHDs that only served suburban and/or rural populations. We did not find statistically significant relationships between other organizational characteristics and gaps or strategies identified by LHDs.

Table 4 presents findings from multivariate analyses examining specific strategies identified within

TABLE 1
Agency Characteristics of Accredited Local Health Departments (N = 183)

Local Health Department Characteristics	n (%)
Size of population served by LHD	
Small (<50k)	45 (24.6)
Medium (50-499k)	101 (55.2)
Large (500k+)	37 (20.2)
Accreditation	
Documentation provided for initial accreditation	154 (84.1)
Documentation provided for reaccreditation	29 (15.8)
Appointing authority	
Other	74 (40.4)
Board of Health	55 (30.1)
County Commissioner	26 (14.2)
Mayor	15 (8.2)
Director of Public Health Umbrella Agency	13 (7.1)
Governance structure	
Decentralized	164 (89.6)
Shared	16 (8.7)
Centralized	3 (1.6)
Jurisdiction	
County	99 (54.1)
City-County	36 (19.7)
District	25 (13.7)
City	19 (10.4)
Town/Township	2 (1.1)
Regional	1 (0.5)
Multijurisdictional (multicounty)	1 (0.5)
Communities served[a]	
Rural	146 (79.8)
Urban	88 (48.1)
Suburban	82 (44.8)

[a]*Categories presented represent all types of communities served by the local health department and are not mutually exclusive.*

TABLE 2
Logistic Regressions Evaluating Agency Characteristics Associated With Workforce Gaps

Agency Characteristic	Planning and Coordination	Leadership	Organizational Culture	Workplace Supports/ Retention	Recruitment	Departmental Training—Planning	Departmental Training—Delivery	Partners and Systems
Population served (Reference: Small (<50k))								
Medium (50-499k)	1.44 [0.54-4.20]	0.61 [0.24-1.49]	0.50 [0.19-1.27]	1.26 [0.48-3.52]	1.10 [0.38-3.51]	0.91 [0.39-2.13]	1.14 [0.51-2.53]	0.71 [0.30-1.67]
Large (500k+)	1.71 [0.44-6.88]	0.53 [0.15-1.75]	0.48 [0.14-1.63]	1.98 [0.53-7.81]	1.04 [0.24-4.65]	1.65 [0.52-5.30]	1.61 [0.52-5.00]	1.08 [0.34-3.40]
Accreditation								
Reaccreditation	2.10 [0.81-5.17]	2.44 [1.04-5.83][a]	1.43 [0.57-3.51]	1.48 [0.56-3.68]	2.94 [1.11-7.52][a]	0.67 [0.26-1.61]	1.74 [0.75-4.21]	0.96 [0.39-2.27]
Appointing authority (Reference: Mayor)								
County Commissioner	N/A	0.65 [0.15-2.78]	0.25 [0.05-1.20]	N/A	N/A	1.01 [0.24-4.13]	0.58 [0.14-2.40]	0.47 [0.11-1.95]
Board of Health	N/A	0.64 [0.17-2.49]	0.43 [0.11-1.70]	N/A	N/A	0.35 [0.09-1.34]	0.75 [0.19-2.78]	0.66 [0.17-2.47]
Director of Public Health Umbrella Agency	N/A	1.01 [0.19-5.26]	1.15 [0.22-5.96]	N/A	N/A	0.56 [0.10-2.92]	0.55 [0.10-2.83]	0.63 [0.11-3.25]
Other	N/A	0.60 [0.16-2.26]	0.52 [0.14-1.95]	N/A	N/A	0.76 [0.20-2.70]	0.83 [0.22-3.01]	0.49 [0.13-1.77]
Governance (Reference: Centralized)								
Decentralized/ Mixed/Shared	N/A	N/A	N/A	N/A	N/A	1.22 [0.42-3.85]	0.84 [0.30-2.35]	1.15 [0.39-3.70]
Jurisdiction (Reference: City/Town/County/ District)								
Multicounty/ Regional	0.87 [0.27-2.45]	1.16 [0.42-3.02]	1.31 [0.47-3.45]	N/A	N/A	0.83 [0.32-2.07]	0.80 [0.33-1.92]	1.83 [0.73-4.55]
LHD types of population served								
LHD serves urban population	0.70 [0.30-1.62]	1.95 [0.89-4.35]	2.01 [0.89-4.70]	1.29 [0.57-2.99]	1.29 [0.52-3.24]	1.45 [0.69-3.11]	0.78 [0.37-1.61]	1.17 [0.54-2.51]

(continues)

TABLE 2
Logistic Regressions Evaluating Agency Characteristics Associated With Workforce Gaps (*Continued*)

Agency Characteristic	Planning and Coordination	Leadership	Organizational Culture	Workplace Supports/ Retention	Recruitment	Departmental Training—Planning	Departmental Training—Delivery	Partners and Systems
LHD serves suburban population	0.97 [0.42-2.19]	1.08 [0.52-2.25]	2.08 [0.98-4.50]	0.43 [0.18-0.98]	0.64 [0.25-1.54]	0.87 [0.42-1.77]	1.55 [0.79-3.06]	1.68 [0.83-3.42]
LHD serves rural population	0.63 [0.26-1.60]	0.52 [0.23-1.23]	0.85 [0.36-2.08]	1.72 [0.30-1.80]	0.45 [0.18-1.19]	1.49 [0.65-3.61]	1.30 [0.57-3.00]	0.65 [0.29-1.51]

Odds ratios are presented in the table.
[a] $P < .05$.
[b] $P < .01$.
N/As indicate the independent variable was removed due to small cell size.

subthemes. LHDs applying for reaccreditation had lower odds (AOR, 0.20; CI, 0.06-0.52) of identifying a strategy related to providing basic public health training for all staff. LHDs in states with decentralized governance structures had lower odds (AOR, 0.25; CI, 0.08-0.86) of identifying a strategy for providing tuition repayment compared to LHDs in a centralized governance structure, whereas LHDs serving urban populations had higher odds (AOR, 2.65; CI, 1.04-7.24) of doing so. Finally, LHDs serving suburban populations had lower odds (AOR, 0.44; CI, 0.22-0.87) of identifying a strategy related to implementing professional development plans.

Discussion

The purpose of this study was to understand LHD characteristics associated with specific workforce challenges and efforts LHDs are implementing to address them. To generate insights, we examined workforce gaps and strategies identified in WDPs representing all LHDs in the United States accredited by PHAB at the time of data collection. While accreditation status and geographic area served were significantly related to specific workforce gaps and strategies, overall, many workforce gaps reported by LHDs are universal and occur irrespective of where the LHD is located or how it is organized. In light of this finding, policymakers and administrators looking to support workforce development efforts among LHDs might seek to develop interventions that address the most common needs shared by LHDs. Additionally, the field would benefit from standards, tool kits, and job aids to enhance the quality and comprehensiveness of WDPs.

We found that accreditation status was significantly associated with the identification of leadership and recruitment gaps, with LHDs undergoing reaccreditation being more likely to identify gaps in both categories. Given that LHDs undergoing reaccreditation have been through the process before, it is possible that these organizations are more likely to identify leadership and recruitment gaps because they have spent more time focusing on workforce development efforts and thus have more comprehensive plans overall. Additionally, LHDs undergoing reaccreditation were less likely to propose the use of a basic public health training as a strategy for workforce development. We suspect that these LHDs likely already have a basic public health training in place; hence, they did not identify it as a specific, planned strategy in their reaccreditation documents.

We also found that LHDs serving urban populations were more likely to identify recruitment strategies and more likely to propose a specific strategy for tuition repayment. Recruiting and retaining

TABLE 3
Logistic Regressions Evaluating Agency Characteristics Associated With Workforce Strategies

Agency Characteristic	Planning and Coordination	Leadership	Organizational Culture	Workplace Supports/Retention	Recruitment	Departmental Training—Planning	Departmental Training—Delivery	Partners and Systems
Population served (Reference: Small (<50k))								
Medium (50-499k)	1.19 [0.53-2.68]	1.76 [0.73-4.41]	1.67 [0.71-4.14]	1.76 [0.73-4.41]	1.17 [0.48-2.84]	2.25 [0.46-11.24]	1.71 [0.68-4.29]	2.18 [0.93-5.33]
Large (500k+)	2.39 [0.73-8.05]	1.26 [0.37-4.34]	1.19 [0.36-4.03]	1.26 [0.37-4.34]	1.94 [0.60-6.37]	1.66 [0.21-12.97]	0.88 [0.26-2.99]	2.18 [0.68-7.18]
Accreditation								
Reaccreditation	1.04 [0.43-2.62]	1.00 [0.40-2.40]	0.97 [0.39-2.32]	1.00 [0.40-2.40]	1.63 [0.68-3.94]	2.44 [0.42-46.58]	1.30 [0.50-3.84]	1.11 [0.45-2.67]
Appointing authority (Reference: Mayor)								
County Commissioner	0.85 [0.19-3.63]	0.55 [0.12-2.45]	0.57 [0.13-2.52]	0.55 [0.12-2.45]	0.88 [0.20-3.95]	N/A	N/A	0.44 [0.10-1.87]
Board of Health	1.07 [0.25-4.17]	0.76 [0.20-2.99]	0.74 [0.19-2.92]	0.76 [0.20-2.99]	1.25 [0.32-4.99]	N/A	N/A	1.16 [0.31-4.38]
Director of Public Health Umbrella Agency	1.02 [0.18-5.81]	1.07 [0.19-5.80]	0.89 [0.17-4.64]	1.07 [0.19-5.79]	1.74 [0.33-9.40]	N/A	N/A	0.52 [0.09-2.72]
Other	1.27 [0.31-4.78]	0.90 [0.24-3.40]	0.87 [0.24-3.30]	0.90 [0.24-3.40]	2.61 [0.71-10.19]	N/A	N/A	1.02 [0.28-3.68]
Governance (Reference: Centralized)								
Decentralized/Mixed/ Shared	1.59 [0.55-4.52]	2.34 [0.75-9.03]	N/A	2.34 [0.75-9.03]	0.52 [0.18-1.51]	N/A	N/A	1.17 [0.40-3.71]
Jurisdiction (Reference: City/ Town/County/District)								
Multicounty/Regional	1.62 [0.65-4.39]	1.51 [0.60-3.74]	1.44 [0.58-3.54]	1.51 [0.60-3.74]	0.91 [0.35-2.30]	1.84 [0.31-35.26]	N/A	1.37 [0.12-0.98]
LHD type of population served								
LHD serves urban population	1.61 [0.76-3.44]	1.61 [0.74-3.54]	1.76 [0.83-3.81]	1.61 [0.74-3.54]	2.83 [1.32-6.25][b]	1.86 [0.18-3.79]	0.85 [0.37-1.90]	1.31 [0.62-2.77]
LHD serves suburban population	0.83 [0.41-1.68]	0.89 [0.43-1.82]	0.92 [0.45-1.88]	0.89 [0.43-1.82]	0.67 [0.32-1.37]	0.47 [0.11-1.81]	0.16 [0.54-2.58]	0.91 [0.45-1.83]
LHD serves rural population	1.43 [0.60-3.38]	1.64 [0.69-4.17]	1.55 [0.65-3.94]	1.64 [0.69-4.17]	0.78 [0.33-1.85]	1.76 [0.11-3.25]	1.63 [0.68-3.75]	0.91 [0.40-2.10]

Odds ratios are presented in the table.

[a] $P < .05$.

[b] $P < .01$.

N/As indicate the independent variable was removed due to small cell size.

TABLE 4
Logistic Regressions Assessing Agency Characteristics Associated With Workforce Subtheme Strategies

Agency Characteristic	Assess Staff Satisfaction	Offers Pro/ Retrospective Tuition/Loan Repayment	Establish Learning/ Innovation Culture	Strengthen Organization Inclusion/ Diversity/ Cultural Sensitivity	Engage With Colleges/ Universities	Preparing Workforce for Community Engagement	Implement Individual Professional Development Plans or Incorporate Professional Development Goals Into the Appraisal/ Review Process	Provide Basic Public Health Training for All Staff
Population served (Reference: Small (<50k))								
Medium (50-499k)	0.66 [0.25-1.74]	1.01 [0.32-3.55]	0.82 [0.30-2.33]	1.44 [0.58-3.76]	0.69 [0.23-2.09]	1.90 [0.82-4.66]	1.65 [0.74-3.76]	2.18 [0.94-5.27]
Large (500k+)	0.41 [0.10-1.57]	1.52 [0.38-6.69]	0.84 [0.22-3.29]	2.50 [0.76-8.67]	2.68 [0.63-12.48]	1.28 [0.40-4.14]	1.41 [0.44-4.54]	2.66 [0.83-8.86]
Accreditation								
Reaccreditation	1.45 [0.52-3.71]	1.26 [0.44-3.25]	1.84 [0.68-4.67]	1.10 [0.43-2.64]	N/A	1.13 [0.47-2.62]	0.91 [0.38-2.11]	0.20 [0.06-0.52][b]
Governance (Reference: Centralized)								
Decentralized/ Mixed/Shared	N/A	0.25 [0.08-0.86][a]	0.36 [0.12-1.18]	N/A	N/A	1.39 [0.48-4.68]	0.76 [0.27-2.07]	0.91 [0.32-2.67]
Jurisdiction (Reference: City/Town/County/ District)								
Multicounty/ Regional	N/A	1.17 [0.33-3.56]	N/A	0.76 [0.26-1.99]	1.41 [0.42-4.14]	0.49 [0.17-1.28]	1.00 [0.41-2.39]	0.99 [0.39-2.45]
LHD type of population served								
LHD serves urban population	1.36 [0.58-3.25]	2.65 [1.04-7.24][a]	0.85 [0.35-2.06]	0.85 [0.39-1.82]	1.59 [0.58-4.58]	1.32 [0.64-2.74]	1.02 [0.49-2.15]	1.19 [0.57-2.50]
LHD serves suburban population	1.01 [0.44-2.26]	1.51 [0.62-3.67]	1.73 [0.74-4.10]	1.07 [0.51-2.22]	0.42 [0.14-1.10]	0.94 [0.47-1.86]	0.44 [0.22-0.87][a]	1.54 [0.77-3.08]
LHD serves rural population	0.50 [0.21-1.26]	0.79 [0.31-2.19]	0.55 [0.22-1.45]	0.66 [0.30-1.51]	2.16 [0.73-7.77]	0.86 [0.39-1.92]	1.71 [0.76-4.04]	1.66 [0.74-3.87]

Odds ratios are presented in the table.

[a] $P < .05$.

[b] $P < .01$.

N/As indicate the independent variable was removed due to small cell size.

Implications for Policy & Practice

- Accreditation data provide insight into the workforce challenges LHDs are experiencing, which can help inform efforts to increase organizational readiness to serve communities.
- Accrediting bodies and policymakers may use this information to provide tailored guidance to LHDs, which helps to bridge gaps in workforce development and aids in refining workforce strategies.
- Given that many workforce gaps identified by LHDs were not related to specific organizational characteristics, efforts to support LHDs in workforce development should focus on the most commonly identified needs.
- To help facilitate efforts to address the most pressing challenges experienced by LHDs, we recommend that LHDs prioritize or rank their workforce gaps in future WDPs.
- We also recommend that future assessments examine the relationship between workforce gaps and LHD performance in terms of how well they are doing on population health outcomes.
- Leveraging insights from WDPs and providing LHDs with additional support can contribute to a stronger workforce resulting in more effective responses for the populations they serve.

public health employees is a longstanding challenge impacting the functioning of the public health system, and offering competitive benefits has been shown to significantly influence governmental employees' decisions regarding where to work.[16] Given rising tuition and debt levels, tuition reimbursement is a promising strategy for strengthening the public health workforce.[17] Our finding that LHDs serving urban areas are more likely to propose these strategies in their WDP is not surprising, given that LHDs serving urban populations are likely located in communities with more resources and more competitive workforce markets. Future research should examine the influence of environmental market factors on workforce gaps and strategies identified by LHDs.

This study has strengths and limitations. As the first study to examine the relationship between organizational characteristics and workforce gaps/strategies identified in WDPs from all accredited LHDs, this study provides a significant contribution to the literature. While our study is inclusive of all accredited LHDs at the time of PHAB data collection (January 2022), it is well documented that smaller LHDs, which make up a large portion of LHDs nationally, are less likely to be accredited.[18,19] Thus, our findings are not generalizable to LHDs nationwide, and some characteristics of accredited LHDs differ from unaccredited LHDs. It is also possible that specific domains defined by PHAB standards may have influenced the workforce gaps and strategies identified by LHDs in their WDPs. Additionally, our study period overlaps with the onset of the COVID-19 pandemic, which may have influenced gaps and strategies identified by LHDs undergoing accreditation during this time. Finally, we were only able to code gaps and strategies identified in WDPs and we were only able to examine organizational characteristics made available to us from PHAB. It is possible LHDs are implementing additional workforce development strategies not reflected in these documents. It is also possible that other organizational characteristics may influence workforce gaps and strategies identified in WDPs. Future research should examine additional organizational characteristics, such as staffing and budgetary information.

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Public Health Accreditation Board Accreditation and Pathways Recognition Among Small Health Departments: Motivation, Communication, and Celebration

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ABSTRACT

This paper explores how small local health departments (LHDs) motivated staff members, communicated progress toward Public Health Accreditation Board accreditation or Pathways Recognition, and celebrated interim and final accreditation accomplishments. Qualitative key informant interviews were conducted with 22 employees and affiliates of 4 LHDs with jurisdiction populations <50 000. LHDs motivated staff through ownership, creative strategies to monitor and record progress, and meaningful no- or low-cost incentives. Participants communicated accreditation progress internally and externally through in-person and electronic communication. Individuals described small rituals and large, community-wide celebrations to express collective investment in and ownership of the accreditation process. Strategies to motivate staff were top-down and bottom-up, and accreditation status updates were communicated through multiple channels. Participants viewed celebrations as valuable aspects of the accreditation process. Reaccreditation participants deemed Public Health Accreditation Board accreditation worthy of celebration and an accomplishment to share with the community.

KEY WORDS: accreditation, celebration, communication, motivation, Pathways Recognition, Public Health Accreditation Board

"Celebrations ... are highly visible ways for you to affirm shared values, mark meaningful progress, and create a sense of community."[1]

Introduction

Proportionally fewer small local health departments (LHDs) have sought Public Health Accreditation Board (PHAB) accreditation than state and large city and county local governmental health departments.[2-4] Challenges for small LHDs have included limited staff time and funding and staff turnover.[2,5-6] Reported benefits of PHAB accreditation, however, are significant

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P.A. was the principal investigator of the study. With P.A., M.F. co-led project design, interview guide development, thematic analyses, case narrative writing, and report development. P.A., M.F., and A.N.C. conducted interviews, qualitative data coding, and thematic analyses. P.C.E. and R.C.B. advised the study team on methods, data instrument development, and reports. B.L. and A.B.T. guided the selection and recruitment of participating health departments, provided input throughout, and edited case narratives. All authors provided intellectual content to the project and manuscript, provided critical edits on article drafts, and approved the final version of the manuscript.

This work was supported by the Public Health Accreditation Board through funding from the Centers for Disease Control and Prevention under Grant Number NU90TO000002. Support was also received through the Centers for Disease Control and Prevention under Grant Number U48DP006395.

We thank the interview participants for their time and perspectives. We also thank Renee Parks, Senior Research Manager, for formatting support, and Mary Adams and Linda Dix for administrative support at the Prevention Research Center at Washington University in St. Louis.

Ethical approval as an exempt study was obtained from the Institutional Review Board at Washington University in St. Louis on November 13, 2023 (identification no. 202310219).

The authors declare that they have no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002085

and include increased use of evidence-based practices; greater collaboration with others; and strategic alignment of goals, community needs, and process and quality improvement efforts.[2,6] Consequently, research questions regarding accreditation often focus on the *why* rather than the *how*.[7] In this Research Brief Report, our study team explored how small LHDs motivated staff members, communicated progress toward PHAB accreditation or Pathways Recognition, and celebrated accomplishments, including achievement of initial accreditation.

Background

In spring 2024, PHAB invited our research team to conduct qualitative interviews with leaders, staff, and affiliates of 4 small LHDs regarding their experiences of accreditation, reaccreditation, or Pathways Recognition using the PHAB Standards & Measures Version 2022. Three of the health departments were in the process of securing reaccreditation; the fourth was in the final stages of participating in PHAB's Pathways Recognition program. Pathways Recognition is a program initiated in 2022 to support performance improvement efforts, strengthen infrastructure, and facilitate public health transformation for local, tribal, and territorial public health departments not yet ready to pursue full accreditation.

Methods

For this descriptive qualitative study, our research team used a semi-structured interview guide to conduct in-depth interviews with 22 employees and affiliates of 4 small governmental health departments with jurisdiction populations <50 000. Participants held many of the same roles across health departments; however, there were different configurations based on the size of the health department and individual roles in the accreditation process. Roles included director, deputy director, leadership team member (eg, unit member), coordinator, or member of an LHD governing body.

LHDs were selected from a small pool of eligible health departments (n = 12) that were using the PHAB Standards & Measures Version 2022 for Pathways Recognition, accreditation, or reaccreditation (as identified by PHAB).[8] Of the 12 eligible LHDs, 7 were invited, 4 agreed to participate, 1 accredited county LHD declined, and 2 county LHDs in the Pathways Recognition program did not respond to emailed invitations. Questions regarding motivation, communication, and celebration comprised a subset of the larger interview protocol, which allowed for a more targeted, practice-based investigation. Institutional Review Board approval was received as an exempt study by Washington University in St Louis (IRB-202310219). Participants gave verbal or emailed informed consent.

Participating Health Departments

One LHD was a single county health department in the Midwest governed by a small local board of health (Reaccreditation; 5 interviews). The second was a district health department that served rural midwestern counties and was governed by a larger board of health (Reaccreditation; 6 interviews). The third was a small tribal health department in the Northwest that had recently formed a separate public health unit (Pathways Recognition; 4 interviews). The fourth was a public health unit that served a small midwestern tribal nation. The tribal public health units included traditional tribal community health services and are governed by both their comprehensive health department leadership and a governing body comprising elected tribal members who represent the full tribal membership (Reaccreditation; 7 interviews). Notably, this study included 2 tribal health departments, which makes an important contribution to the existing research literature.[5]

Data Collection and Analysis

Key informant interviews lasted approximately 60 minutes and were audio recorded via Zoom. Audio recordings were transcribed verbatim by a third-party vendor. A team member checked each recording against the transcript for accuracy. Two team members independently coded each interview transcript and came to agreement on codes. Pairs of team members then identified themes, conducted consensus theming, and prepared theme statements.

Research team members used NVivo 20 for data management and coding. The 3 coauthors who conducted interviews developed and revised a codebook based on pilot interviews.[9] We followed Standards for Reporting Qualitative Research (SRQR) Standards for Reporting Qualitative Research[10] and the COnsolidated criteria for REporting Qualitative research (COREQ) Checklist.[11]

Findings

In this section, we describe strategies LHDs used to motivate staff members, communicate progress, and

celebrate accomplishments, specifically the attainment of initial accreditation among the 3 LHDs pursuing reaccreditation. Table 1 provides illustrative quotes.

Motivating Staff

Participants described initial efforts to motivate staff to take ownership of the process. LHDs achieved staff ownership and engagement by involving all staff on domain teams; inviting staff to choose and take responsibility for sections that fit their work; eliciting staff feedback; communicating the *what* and *why* of accreditation to establish a shared vision; and providing one-on-one mentoring for new staff.

Participants also described motivating staff through visual displays. Three of the 4 LHDs created leaderboards that tracked progress toward completion of the PHAB Standards & Measures via mascot animals moving along a timeline or racetrack. For reaccreditation, 1 LHD created an image of a limousine that followed the "road to reaccreditation." Members of this health department also developed a Hollywood theme and red-carpet event with VIP passes for staff to introduce the limousine concept.

Like the leaderboard concept, 1 LHD used a pie chart with each "pie piece" representing one of the PHAB domains. Completion of each domain resulted in an informal "jeans day" among staff. Participants discussed other strategies their health departments used to motivate staff including food, time off, and theme-inspired incentives (ie, tumbler). Participants from this last health department noted that the theme "Challenge Accepted" was created by a staff member. Another LHD found weekly quizzes for gift card drawings a motivating and fun way to help new staff learn about accreditation.

Communicating Progress

Individuals identified multiple ways in which they communicated progress toward goal completion, both internally and externally. LHDs provided progress updates to staff through formal in-person gatherings (ie, quarterly all-staff meetings), as well as less formal assemblies (ie, morning huddles). LHDs also communicated progress electronically through email messages and via Microsoft Teams to inform team members of progress and to "give credit where credit is due." LHDs updated governing boards and other organizational units through email and presentations at board meetings.

Regarding external communication, participants identified both traditional and social media platforms and LHD websites as mechanisms for updating the community of their progress. For tribal LHDs, news was frequently shared through a tribal newsletter and email messaging. LHDs also used external signage and displays to demonstrate to community members their status as PHAB-accredited.

Celebrating Accomplishments

Participants from one LHD talked about small celebrations to acknowledge the successful completion of intermediate accreditation steps by "trying to make [the accreditation process] feel fun." One individual expressed great enthusiasm for simply changing the color on their spreadsheets to represent the achievement of specific accreditation criteria. Recognizing the value of short-term goals toward accreditation, one LHD leader stated, "small wins are big wins." In one case, members of the LHD displayed a plaque with everyone's signatures, which acknowledged their achievement of PHAB accreditation.

Two LHDs described large celebrations that occurred upon attainment of initial accreditation. Festivities included recognition by a governing board by one and the Chamber of Commerce by another. Celebrations also included press releases and a photo op accompanied by news articles, a ribbon-cutting ceremony, and a health department tour.

Discussion

Participants described formal and informal strategies they used for PHAB accreditation or Pathways Recognition. While many successful strategies were consistent across both small tribal and non-tribal health departments, tribal health department participants provided important perspectives on the unique governance and situation of each tribal nation that affects the processes. In terms of motivating staff, LHDs developed multiple ways to engage staff and achieve staff ownership[12] and creative strategies to monitor and record progress toward completing PHAB Standards & Measures.[13] As governmental health departments, funds are often restricted for incentives; however, LHDs leveraged no or low-cost items to motivate staff in ways that were meaningful to them. Notably, the most valuable items and activities seemed to originate from staff members themselves, which speaks to the power of ownership of the accreditation process.

LHDs used multiple strategies to communicate their accreditation progress, both internally and externally, using in-person and electronic communication to convey intermediate progress and goal completion. Participants expressed the importance of keeping everyone informed of their progress toward accreditation since individuals frequently worked on

TABLE 1
Strategies to Motivate Staff, Communicate Progress, and Celebrate Accomplishments

Domain	Illustrative Quote	Local Health Department	Role
Motivate staff			
Staff ownership	"We include employees in about everything. Very rarely is a decision just made and forced on them. We ask for their feedback constantly.... So I think being able to give people a voice in change is really important too."	1	Deputy Director
	"And then the things that have to be changed. Doing that brainstorming ... involving them in the change. Trying to figure out any unanticipated consequences to that change and addressing those so people feel supported here and valued."	1	Director
	"We have a really good responsive staff who focus on our community and focus on the needs of the community and understand how valuable our work is to that."	4	Case Management Manager
	"We're always challenging and encouraging staff to make improvements in processes."	2	Director
Leaderboard	"Each team, each [Standards & Measures] domain had a [mascot animal]. And when we would make progress through each determined benchmark, then we would get to move our [mascot animal] to the next one until we all ended up ... together."	1	Director
	"We actually did a Kentucky Derby-type race where each domain was a horse."	2	Director
	"They [staff] went and took pictures of everybody and they put them ... in this limousine, and so it shows everybody in this limousine car tracking along the road of PHAB, the road to reaccreditation."	2	Intranet Manager & Accreditation Coordinator
Small incentives	"For each domain, we had a little pie chart, so we colored in each domain as we fulfilled it, and every time a domain was done, we would get a 'jeans day.' I know that sounds like no big deal, but to staff members, it's nice to be casual every once in a while. So, we would always look forward to, okay, when's the next domain going to get done so we can get an extra jeans day? So, that was kind of fun, and it was a way to include everybody in the celebration."	4	Population Health & Preparedness Manager
	"Whether it's letting people have the afternoon off or a pizza party or just something to say, 'hey, we did this,' and everybody plays a part in it, whether you're a [project] lead or a coordinator."	1	Deputy Director
	Accreditation theme: "Challenge Accepted". All staff members received tumblers with the theme "So we kind of just owned it with a little tag like that."	4	Health Promotion Manager
Communicate progress			
Internally	"And I guess just sitting there as a team too, to celebrate and give little high-fives and whatnot to say, 'all right, I think we've got it.'"	1	Environmental Health Manager
	"So, every morning we have what we call a morning huddle ... And that gives us a really great opportunity to really talk about each of those wins."	2	Deputy Director
	"Anytime something is relevant or happening related to accreditation or we've accomplished something, we'll post it there [in Teams]."	2	Deputy Director
	"Recognition via messages in [Microsoft] Teams or email."	1	Environmental Health Manager
	"Give credit where credit is due ... especially when it comes from someone in upper management."	1	Evaluation Manager & Accreditation Coordinator
	"They [Leadership] were communicating to us frontline staff members. I felt a part of it in that way because they were sharing our progress and communicating with us."	4	Health Promotion Manager

(continues)

TABLE 1
Strategies to Motivate Staff, Communicate Progress, and Celebrate Accomplishments (*Continued*)

Domain	Illustrative Quote	Local Health Department	Role
Externally	"Our website ... it states right here that we're an accredited public health department. The window, when they [community members] walk back here to our department, it's got the public health accreditation emblem right on the window. We have a plaque hanging up in the front, so it's ever-present for them to see."	4	Case Management Manager
	"We're pretty good about putting stuff out on social media or by press release .... I know last time we got accredited [there were] things on the doors so people would know, 'Hey, we're accredited here in our department.'"	1	Environmental Health Manager
	"I think there's a lot of communication of what we do. We have a lot of stuff on social media, out in the communications of the [Tribal Nation], which could include the Tribal newsletter, the Tribal emails. I know some managers are, of course, in local meetings with other public health directors in regions in [state], so some of that is shared there."	4	WIC/Nutrition Manager
	"I know we invested in the signage that displays our accreditation [status] on the outside of our department."	4	Community Health Manager
Celebrate accomplishments			
	"We would find great joy in turning our spreadsheets green when we get criteria done. So everything, every cell, when it was done, we'd turn green so our PHAB coordinator would know it was done, our team would know it was done. It was just our signal to be like, 'Hey, it's done.'"	1	Environmental Health Manager
	"Trying to make it feel fun, putting celebratory things up in the room, hosting, having time away from the office."	2	Accreditation Consultant
	"I know one of the things that we did is we created our own plaque to celebrate and had people sign it. Then we shellacked it that we met the challenge."	4	Community Health Manager
	"The Chamber of Commerce came out ... and there were all kinds of community members there. They did a news interview and paper interview ... and we had a ribbon cutting of our department. And, of course, we had a tour of our facility."	2	Director
	"With our [initial] accreditation, we had a really big celebration. Our [governing body] honored our work. We had cake.... We all got certifications. We had photo op things, and there was a big article about it in our Tribal newspaper."	4	Director

different priority areas and could be *siloed* from other teams. Individuals also described communication as an expression of appreciation for individual and team efforts toward accreditation or Pathways Recognition. Staff especially valued expressions of gratitude from members of the leadership team.

Participants identified multiple ways in which they communicated their achievement of initial accreditation with the community via traditional and social media coverage, as well as through signage and other visual imagery. Individuals expressed great pride in sharing this accomplishment with community members, noting that official recognition as a PHAB-accredited health department was an endorsement of high-quality services.[14-15] The accredited tribal health department communicated directly with community members via tribal newsletters and email messaging. Despite the challenges of attaining initial accreditation, or perhaps because of them, LHDs wanted others to know they had achieved this recognition.

Finally, participants described how they celebrated successes associated with PHAB accreditation and Pathways Recognition. Individuals discussed small rituals they created to observe progress toward goals (eg, changing colors in Excel spreadsheets) and large, community-wide celebrations that recognized their successful attainment of initial accreditation. Celebrations, large and small, represented individual and collective investment in and ownership of the accreditation process.[14] Participants suggested that achieving PHAB

Implications for Policy & Practice

- Incentives for staff can be no or low cost if they are meaningful to individuals.
- Strategies to motivate, communicate, and celebrate foster a sense of ownership.
- Successful ideas and activities for accreditation are frequently staff-generated.
- Pursuit of accreditation or Pathways Recognition should involve everyone.
- "Small wins are big wins."

accreditation was worthy of celebration and an accomplishment that should be shared with the community.

Conclusion

LHDs confirmed that PHAB accreditation and Pathways Recognition are challenging yet worthwhile. Strategies to motivate staff were both top-down and bottom-up, and status updates were communicated internally and externally through multiple channels. Celebrations occurred through small rituals and large gatherings, and participants suggested both were valuable aspects of the accreditation process. This investigation focused on small LHDs; however, lessons could be easily adapted to meet the needs of larger local, state, tribal, or territorial health departments.

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PHAB

Building the Foundation for a High-Performing Public Health System

Erika G. Martin, PhD MPH

During the height of COVID-19, public health experts resolved to "reimagine" the public health system to address critical issues exposed by the pandemic including insufficient preparedness and surveillance capabilities, worsening health inequalities, and misinformation.[1] Increased rates of chronic disease and deficiencies in the COVID-19 response have been attributed to persistent underinvestment in public health infrastructure and workforce; these chronic funding shortfalls are exacerbated by disease-siloed funding streams and boom-and-bust funding cycles.[2,3] The politicization of public health since the COVID-19 pandemic has further challenged the public health system and workforce.[4]

Over the past 15 years, accreditation has become an increasingly visible strategy to strengthen public health infrastructure and promote quality improvement. Health departments seeking accreditation by the Public Health Accreditation Board (PHAB), the only national accreditation body for governmental public health, must meet evidence-based standards that are informed by public health experts, align with the Foundational Capabilities, and undergo periodic review to ensure relevance to the evolving field. Through the accreditation process, health departments strengthen their quality improvement and performance management practices and work to demonstrate achievement of the Foundational Public Health Services.

The articles in this issue provide important evidence about the value and impact of accreditation, and health departments' accreditation experiences. In their commentary, Kuehnert and Bender provide a historical perspective of the evolution of national voluntary public health accreditation and the growing evidence base on the value and impact of accreditation, urging health departments to start their accreditation journeys.[5] Davis et al use COVID-19 as a natural experiment to examine associations between local health department (LHD) accreditation and population health outcomes, finding higher COVID-19 vaccination rates and lower COVID-19 mortality rates among counties with accredited health departments.[6] Four qualitative articles by a second team of researchers examine the experiences of small LHDs that were working towards reaccreditation or Pathways Recognition from PHAB, providing rich detail on diverse topics including quality improvement and performance management, strategies to overcome accreditation challenges, and strategies to motivate staff.[7-10] Oberly et al document the experiences of LHDs achieving accreditation in Ohio, an interesting case study as the only state with a national accreditation mandate.[11] Burns et al review workforce development plans submitted to PHAB during accreditation to assess relationships between identified workforce gaps and LHD characteristics.[12]

As more health departments become accredited, there are several opportunities for future analysis. The first is applying quantitative methodologies to examine the causal impact of accreditation and economic returns on investment. These methods are increasingly feasible as more health departments become accredited and additional time elapses since initial accreditation to assess changes in long-term population health outcomes. Such analyses could explore the variation in accreditation-related outcomes between different types of health departments. Second, PHAB has robust research data available upon request that have not been used to their full potential. Potential studies include assessing compliance with PHAB's standards and measures; analysis of surveys completed by health departments during different stages of the accreditation process regarding self-reported changes in quality improvement, workforce, accountability, use of evidence-based practices, resource utilization, and other topics; using health department survey data and achievement of relevant

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This work was supported by funding from the Centers for Disease Control and Prevention under Grant Number NU90TO000002. The Robert Wood Johnson Foundation provided funding for the special section under Grant ID 79215.

The author declares no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002111

standards and measures to study changes in practices to achieve health equity; and in-depth analysis of health departments' submitted plans to identify gaps and strategies.[13] While the articles in this issue "provide some long-awaited answers" to questions about the value and impact of accreditation,[5] they also prompt future inquiry into this critical area of public health infrastructure.

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Research Full Report

PHAB

Examining the Association Between Public Health Accreditation and COVID-19 Outcomes

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ABSTRACT

Objective: To examine the association between local health department (LHD) accreditation and COVID-19 community outcomes, including rates of adult vaccination, hospitalization, and death.

Design: We examined county level rates of adult vaccination, hospitalization, and death by LHD accreditation status over the course of the COVID pandemic. Additional independent variables included time period, COVID-19 Community Vulnerability Index (CCVI), state public health governance structure, and state policy environment. We used hierarchal linear mixed modeling with random intercept for county level data to account for repeated observations and fixed effects for all other variables.

Setting: This study examined all communities in the United States of America.

Participants: LHDs and the communities they serve.

Main Outcome Measures: Rates of adult vaccination, hospitalization, and death due to COVID-19.

Results: Among accredited LHDs, the adult population was more likely to be fully vaccinated when compared to unaccredited LHDs ($P < .01$). Additional variables in the model, which were also significant, included time period, CCVI, state policy environment, and state public health governance structure. There were no significant differences in the hospitalization rates in jurisdictions with an accredited LHD compared to jurisdictions where the LHD is not accredited. Death rates in jurisdictions with an accredited LHD were statistically significantly lower than death rates in jurisdictions where the health department was not accredited ($P < .001$). This relationship was significant with other key variables in the model, including time, CCVI, state policy environment, and state public health governance structure.

Conclusions: This study demonstrates that there is an association between LHD accreditation and community health outcomes. Furthermore, we found that other factors, such as social determinants of health, state policy environment, and state public health governance structure impact community health outcomes.

KEY WORDS: accreditation, community health, COVID-19, public health

More than 100 million cases of COVID-19 with nearly 1.2 million deaths were reported in the United States through May of 2023.[1] Vulnerable populations including the elderly and communities with systemic challenges that affect the social determinants of health, such as environments that lack food availability, education and employment opportunities, access to health care, public safety and safe affordable housing, have been more likely to experience adverse effects from the virus, including higher rates of hospitalizations and deaths.[1,2] This follows the general trend that those with the fewest economic resources have 67% excess mortality compared to those with the greatest economic resources.[3]

Following multiple threats to health and safety in the fall of 2001 and recognizing the critical role that public health systems play in community preparation and response to health threats and emergencies, the Federal government has invested in tools to support state and

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The authors would like to thank Matthew Pappalardo for his assistance with preparing manuscript tables. This work was supported by the Public Health Accreditation Board (PHAB) through funding from the Centers for Disease Control and Prevention (CDC) under Grant Number NU90TO0000002.

This work was supported by the Public Health Accreditation Board through funding from the Centers for Disease Control and Prevention under Grant Number NU90TO000002. The Robert Wood Johnson Foundation provided funding for the special section under Grant ID 79215.

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DOI: 10.1097/PHH.0000000000002100

local public health systems over the last 2 decades.[3,4] While these investments have led to improvements in medical countermeasures, such as vaccines, improvements have often been isolated, resulting in minimal positive change to sustainable public health infrastructure to address multiple public health threats.[5]

Previous research suggests that public health departments that have achieved accreditation through the Public Health Accreditation Board (PHAB), the national accrediting body for public health, demonstrate improvements in infrastructure, including capacity building and capabilities related to preparedness.[5] An additional study found that health departments participating in a state-based accreditation system performed better on 4 of 8 preparedness capacities and those that participate in performance improvement programs performed better on 7 of 8 preparedness capacities compared to health departments that had not participated in any performance improvement effort.[6] More recently, one study indicated that communities with stronger public health capabilities, as measured by implementation of 20 recommended public health activities within a community, experienced significantly fewer deaths in 2020 from COVID-19.[7]

As depicted in the Public Health Accreditation Board's Logic Model,[8] health departments that participate in the PHAB accreditation process improve preparedness through creating or adapting policies and procedures as well as ensuring partnerships are in place with pertinent organizations to adequately prepare for and respond to man-made, natural, and other disasters. Documentation of policies, procedures, and partnerships provides evidence that the health department meets PHAB's Standards & Measures requirements. While requirements pertaining to preparedness are primarily found in Domain 2 of the Standards & Measures, *Investigate, diagnose, and address health problems and hazards affecting the population*, health departments that meet the Standards & Measures in other domains with topic areas such as workforce development, quality improvement, partnership facilitation, and evidence-based decision-making may experience enhanced preparedness as well. The Florida Department of Health has reported that preparing for and maintaining accreditation bolstered preparedness planning and response efforts to address the Zika virus in the state. Specifically, accreditation preparation supported the creation of integrated surveillance systems and successful implementation of risk communication, community engagement, and collaboration with vendors to meet testing needs.[9]

The COVID-19 pandemic placed an extraordinary burden on and emphasized the critical role of State, Tribal, Local, and Territorial public health departments to protect the health of the citizens they serve. Accredited health departments have reported that preparing for accreditation facilitated their response to COVID-19.[10] Eighty percent of accredited health departments reported that accreditation overall assisted the health department in better responding to the COVID-19 pandemic.[5]

While there is growing evidence that accredited public health departments do have enhanced capability and capacity to address various threats and hazards, research is lacking on the relationship between health department participation in accreditation and better community health outcomes. This article examines whether accredited public health departments were better poised to mitigate the impact of the COVID-19 pandemic compared to non-accredited health departments regarding COVID vaccination rates and hospitalizations and deaths attributed to COVID.

Methods

Grounded in research questions and outcomes from the PHAB Logic Model and Research Agenda, this study was designed to understand if health outcomes related to COVID-19 differed by public health department accreditation status. Outcomes of interest included COVID-19 hospitalization and death rates per 100 000 due to COVID-19 and percentage of the adult population vaccinated against COVID-19 (Table 1). Vaccine[11] and death rate[12] data by county were downloaded from the Centers for Disease Control and Prevention's (CDC) publicly available databases and hospitalization rate data by county was accessed through the COVID-19 Data Repository by the Center for Systems Science and Engineering at Johns Hopkins University.[13]

Independent variables (Table 1), included time periods categorized by vaccine availability, public health department PHAB accreditation status, COVID-19 Community Vulnerability Index (CCVI),[14] state public health governance structure, and state policy environment. To understand the impact of time on outcomes, the study team created a categorial variable defining 4 distinct time periods based on vaccine availability during the pandemic: limited vaccine availability (December 14, 2020-April 18, 2021); wide vaccine availability following the White House declaration that all people age 16 and older were eligible for COVID-19 vaccine (April 19, 2021-September 24, 2021); limited booster availability following the HHS directive to allow a booster dose of the Pfizer COVID-19 vaccine to certain populations (September 25, 2021-November 20, 2021; and wide booster availability (November 21, 2021-May 12, 2023 when CDC vaccination data were no longer updated).

We examined local public health departments (LHDs) that represented local jurisdictions (single

TABLE 1
Dependent and Independent Variable Descriptions

Dependent variable	Definition
Percent vaccinated adults by county	Percentage of adults aged 18+ who completed a primary vaccine series (had a second dose of a 2-dose vaccine or 1 dose of a single-dose vaccine) by time period.
Hospitalizations per 100 000 population	Total weekly hospitalizations aggregated across each time period divided by the 2019 census estimate and multiplied by 100,000.
Deaths per 100 000 population	Total weekly deaths involving COVID-19 (ICD-code U07.1) aggregated across each time period divided by the 2019 census estimate and multiplied by 100 000.
Independent variable	**Definition**
Time period	Categorical variable defining 4 time periods: • T1: Limited vaccine availability (12/20-4/18/21) • T2: Wide vaccine availability (4/19/21-9/24/21) • T3: Limited booster (third dose) availability (9/25/21-11/20/21) • T4: Wide booster availability (11/21/21-5/12/22)
PHAB accreditation status	Categorical variable indicating PHAB accreditation status as in process, accredited, or not accredited as during the study time period. If a health department became accredited during the study period, it was considered accredited. Data were provided by PHAB through a data use agreement.
CCVI[a]	The CCVI builds on the CDC's Social Vulnerability Index, to account for COVID-specific epidemiological risk factors, public health and health care system capacity, and variables capturing specific high-risk environments known to facilitate the spread of COVID-19.
State public health governance structure[b]	Categorical variable based on the 2019 NACCHO Profile LHD governance classification. Structures were determined by NACCHO and fall into 1 of 3 categories: • Decentralized (all LHDs in the state are units of local government) • Centralized (all LHDs in the state are units of state government) • Shared (all LHDs in the state are governed by both state and local authorities) • Mixed (LHDs in the state have more than 1 governance type)
State policy environment	Categorical variable based on political affiliation of governors from the 2020 election. • More permissive • More restrictive

[a]COVID Community Vulnerability Index.
[b]Data for Rhode Island were obtained from the Rhode Island Department of Health website: *https://health.ri.gov/*.

or multiple counties). During the study time period, 42 of 50 state health departments were accredited providing no variation to examine outcomes at the state level and there was insufficient data on territorial or tribal health departments to examine outcomes among jurisdictions served by these public health departments. LHD PHAB accreditation status was categorized as accredited, in the system (health department is in the PHAB system and is not accredited either because they have not completed the accreditation process or accreditation was not awarded), or not accredited (health department has not completed any activities to begin the accreditation process). The "in the system" LHD category was created to recognize that these LHDs have had some interest and exposure to PHAB standards and measures but the true benefits of that exposure has yet to be measured. For the purposes of this study, an LHD was considered accredited if it was accredited at the beginning of the study period or became accredited during the study period. Forty-four health departments became accredited during the study period.

CCVI, a composite measure of social determinants of health and general health, was calculated using scores from 7 themes: (1) socioeconomic status; (2) minority status and language; (3) household and transportation; (4) epidemiological factors; (5) health care system factors; (6) high-risk environments; and (7) population density. Each theme has a score ranging from 0 (lowest vulnerability) to 1 (highest vulnerability) and thematic scores are aggregated into a county-level composite score from 0 to 1. Public health governance structure was a categorical variable based on the type of LHD governance reported in the 2019 NACCHO Profile of Local Health Departments.[15] The 4 categories included decentralized (all LHDs in the state are units of local government, n = 30); centralized (all LHDs in the state are units of state government, n = 7); shared (all LHDs in the state are governed by both state and local authorities, n = 3); and mixed (LHDs in the state have more than one governance type, n = 10). State policy environment was defined as political affiliation of the governor as a proxy measure of COVID-19 prevention

and control mandates within a state, where Republican affiliation suggested that a state had more permissive mandates (eg, fewer mask mandates and closures) and Democratic affiliation indicated that a state had more restrictive mandates (eg, greater mask mandates and closures).[16]

Other variables considered but not included in the analyses were Social Vulnerability Index (SVI) and state COVID policies. The CCVI variable includes the SVI measures and demographic variables including gender, race, ethnicity, age distribution and population density/rurality. State COVID policies did not overlap well with vaccine availability measures and would have required thousands of additional data points to reflect the various changing executive and legislative actions and court rulings, thus the inclusion of the state policy environment variable.[16]

Institutional Review Board approval was not sought for this study as all data, with the exception of PHAB accreditation status, were publicly available. PHAB provided data on LHD accreditation status as part of the research contract.

Statistical Analysis

Descriptive statistics for all variables were initially conducted with continuous variables reported as mean and standard deviations and categorical variables reported as frequency and percentages. All variables outside of governance structure and state policy environment were county level reported variables and descriptive statistics are conducted at the county level. Data is panel data with one observation for each county for each of the 4 time periods. Due to governance structure and policy environment being at the state level, these categorical variables were thus reported at the state level. We used hierarchal linear mixed modeling with random intercept for county level data to account for repeated observations and fixed effects for all other variables. We used an $\alpha = .05$ as the significance threshold for all variables in model building. Estimated beta coefficients and associated P values are included in the results tables below. All outcome variable regressions included the following independent variables: PHAB accreditation status, time period, COVID-19 CCVI, state policy environment, and governance structure of each state's LHD. Independent variables were constant within each time period, independent variables were assumed to be constant but varied across time periods. In the percentage of adults vaccinated regression, due to insufficient data in the "Time 1" period, we excluded "Time 1" as the reference variable and instead chose to model time against the "Time 2" period. For all other regressions all time periods were used. Including LHDs that became accredited during the study period in the entire study period did not impact outcomes. All statistical analysis was conducted in SAS 9.4.

Results

Table 2 presents descriptive statistics for all variables for the 3011 LHDs included in the analysis by health department accreditation status. During the study period, 2539 health departments were not accredited, 69 were in the system, and 403 were accredited. Forty-four LHDs became accredited during the study period. The mean CCVI for the LHDs was 0.49 or in the mid-range and there was no difference in mean CCVI between health department by accreditation status. The majority of LHDs (61%) are part of a decentralized state public health governance structure and there was a significantly higher percentage of decentralized health departments that were accredited compared with health departments in states with other governance structures. Because states with centralized governance structures are accredited at the state level, not the local level, there were no accredited LHDs in those states. Approximately 55% of LHDs were in states with a more permissive COVID-19 state policy environment and 45% were in states with a more restrictive COVID-19 state policy environment. The percentage of adults vaccinated was significantly higher in accredited health departments and COVID-19 hospital admissions per 100 000 and deaths per 100 000 were significantly lower compared with unaccredited or health departments in the PHAB system.

Percentage of Adults Vaccinated

We found a statistically significant positive association between LHD accreditation status and the percent of the county population that was fully vaccinated (Table 3). Among accredited LHDs, the county adult population was more likely to be fully vaccinated when compared to unaccredited LHDs. This association was significant when accounting for time, CCVI, state policy environment, and state public health governance structure ($P < .001$). There was no difference in the population vaccination status between LHDs in the PHAB system and unaccredited health departments. CCVI was significantly negatively associated with county vaccination rates, State policy environment was significantly associated with vaccination rates where states with more restrictive policies had higher vaccination rates. The percent of fully vaccinated adults in counties with mixed or shared public health governance structure were significantly less likely to be fully vaccinated.

TABLE 2
Descriptive Statistics for Variables of Interest by LHDs Included in Analysis

Variable	Subset	Unaccredited (N = 2539)	In-System (N = 69)	Accredited (N = 403)	*P* Value
CCVI	Mean (Std.)	0.49 (0.29)	0.48 (0.24)	0.48 (0.26)	.64
Governance structure	Mixed	267 (11%)	2 (3%)	76 (19%)	< .001
	Centralized	241 (10%)	-	-	
	Decentralized	1548 (61%)	64 (93%)	297 (74%)	
	Shared	483 (19%)	3 (4%)	30 (7%)	
State policy environment	Restrictive	1151 (45%)	17 (25%)	192 (48%)	.002
	Permissive	1388 (55%)	52 (75%)	211 (52%)	
Percentage of adults vaccinated	Mean (Std.)	55.86 (15.84)	54.04 (13.08)	57.67 (15.73)	< .001
COVID-19 admissions per 100 000	Mean (Std.)	2668.13 (14 898.53)	2257.53 (6045.25)	2170.33 (7509.09)	< .001
COVID-19 deaths per 100 000	Mean (Std.)	93.62 (94.37)	86.89 (76.21)	79.40 (74.88)	.003

Hospitalization Rates

There were no significant differences in the hospitalization rates in counties with an accredited LHD compared to counties where the LHD was not accredited. However, the relationship was in the expected direction with lower admissions per 10 000 in counties where the LHD was accredited. Nor were there any differences between county hospitalizations rates where LHDs were in the PHAB process or not accredited.

Death Rates

We found a statistically significant inverse relationship between COVID-19 related deaths per 100 000 population and accreditation status. Death rates in counties with an accredited LHD were statistically

TABLE 3
Multivariate Analysis Adjusted by Time, State Policy Environment, CCVI, and Governance Structure Across Counties (N = 3011)[a]

	Death per 100 000		Admission per 100 000		Percent Vacinated	
Variable	β (SE)	*P*	β (SE)	*P*	β (SE)	*P*
Intercept	180.01 (1.89)	< .001	1640.57 (461.23)	.001	46.43 (0.57)	< .001
Accreditation status						
Not accredited	-	-	-	-	-	-
In system	−5.74 (4.53)	.21	−643.58 (1188.48)	.59	0.23 (1.61)	.89
Accredited	−13.38 (2.01)	< .001	−420.69 (524.36)	.42	3.08 (0.71)	< .001
Time period						
Time 1	-	-	-	-	-	-
Time 2	−151.73 (1.59)	< .001	2403.61 (315.56)	< .001	-	-
Time 3	−155.50 (1.59)	< .001	−463.84 (315.56)	.14	5.42 (0.16)	< .001
Time 4	−93.84 (1.64)	< .001	2606.40 (326.77)	< .001	11.5 (0.17)	< .001
CCVI	31.32 (2.72)	< .001	564.13 (706.10)	.42	−1.23 (0.95)	.19
State policy env.						
Permissive	-	-	-	-	-	-
Restrictive	−11.57 (1.45)	< .001	−265.00 (375.76)	.48	8.99 (0.50)	< .001
Governance structure						
Decentralized	-	-	-	-	-	-
Mixed	18.03 (2.34)	< .001	−1345.20 (605.89)	.03	−9.07 (0.81)	< .001
Centralized	13.81 (2.67)	< .001	−671.12 (691.04)	.33	2.07 (0.93)	.03
Shared	2.25 (1.98)	.25	−39.08 (510.85)	.94	−1.00 (0.68)	.14

[a]Hierarchal linear mixed modeling with mixed and random effects to address endogeneity was conducted at the county level for all outcome variables.

significantly lower than death rates in counties where the health department was not accredited. This relationship was significant with other key variables in the model, including time, CCVI, state policy environment, and state public health governance structure ($P < .001$). There was no statistically significant difference in death rates between counties where the LHD is in the PHAB system and unaccredited health departments. Additional variables in the model performed as expected with statistically significant decreases in death rates over time. Also, CCVI was significantly positively associated with death rates (Table 3). States with more restrictive policy environments had significantly lower death rates and states with mixed or centralized governance structure had higher death rates.

Discussion

We found an association between LHD accreditation and better COVID-19 population outcomes at the county level, including higher vaccination among adults and lower death rates. As expected, over the time periods in our analyses, vaccine percentages increased across jurisdictions. In the final model, CCVI was negatively associated with higher vaccine percentages among adults. Kasting and colleagues examined social and demographic factors related to COVID-19 vaccine rates in Indiana and found that factors, including demographics and access to care, measured in the CCVI, are associated with COVID-19 vaccine rates.[17] Pima County, Arizona, an accredited LHD, had among the highest percentage of adults vaccinated and has a high Social Vulnerability Index (0.88). Cullen and colleagues explained how this health department focused on equitable vaccine access and distribution throughout the county to mitigate factors that hinder vaccine access and uptake among all adults.[18] All LHDs, including accredited ones, could consider equitable approaches to vaccine distribution as one strategy to increase vaccination rates.

In these analyses, we found that counties with an accredited LHDs had lower death rates than not accredited LHDs. These findings are consistent with a study of early death rates during the COVID-19 pandemic which found that communities with stronger public health capabilities experienced fewer deaths.[7] Again, state public health governance structure and the states with more restrictive pandemic control measures, may have facilitated the efforts of accredited LHDs to minimize unnecessary deaths. In the final model, CCVI was positively associated with death rates which reinforces our understanding of how social and demographic factors impact health.

In contrast, we found no relationship between LHD accreditation status and hospitalization rates. There may have been other factors, such as confirmed number of COVID-19 cases, that were needed in the model. A limitation of this study could be that we did not control for the confirmed number of COVID-19 cases in the models.

In both the vaccination and death rate models, the state policy environment and the state's public health governance structure were significant explanatory variables. While state policies have likely affected public health measures for some time, the COVID-19 pandemic revealed considerable differences in how state policies affected key disease prevention and control measures.[16] State public health governance structure is recognized as an important predictor of LHD performance generally, and specifically for performance of preparedness capabilities, including capabilities associated with pandemic control measures.[19] This study confirms the need to include this key variable in models of LHD performance.

We found no differences in community health outcomes between LHDs that are in the PHAB system and not accredited LHDs. This may be due to the small number of LHDs in the PHAB system and those that are, include ones that may have just begun the accreditation journey or may not have been accredited. Working with PHAB staff, we included this category of LHDs in this study to account for all potential LHD categories. Future research should consider how to account for LHDs that are in the system and are either in the process for accreditation application or have applied but not achieved accreditation.

Limitations

We acknowledge the following limitations to these results. First, there is no national dataset of key variables for PHAB related research, such as PHAB accreditation status for all public health departments with FIPS codes and state public health governance structure. This required building the dataset manually which introduces possible human errors. Such a dataset could provide standardized research approaches for understanding the impact of public health accreditation and encourage research using these data. Second, we intended to examine vaccination rate as a moderating factor in the models where death and hospitalization rates per 100 000 population were the outcomes of interest, but data on vaccination rates for T1 were not available. Third, there was significant missing data that was likely not missing at random. For example, missing data on hospitalization rates tended to be missing from rural counties compared

to less rural counties. For ease of analysis, some independent variables such as governance structure were simplified. Finally, while we were not able to establish a causal relationship between LHD accreditation and these outcomes, these findings do establish that there is a relationship between LHDs achieving accreditation and community outcomes. However, the findings are limited to LHDs and may not be generalizable to other jurisdictions including Tribal and Territorial health departments.

Conclusions

Public health departments achieve PHAB accreditation for a variety of reasons, including: (1) national accreditation can improve quality and performance of public health efforts; (2) assuring their community that they have met national performance standards including the 10 Essential Public Health Services and the Foundational Public Health Services; (3) demonstrating that they have capabilities to meet preparedness standards such as Project Public Health Ready for LHDs and CDC's Public Health Emergency Preparedness cooperative agreement capabilities for state and territorial health departments.[10]

While it is important to demonstrate that the process of accreditation can lead to improvements in capacities and capabilities and improve quality, policy makers and the public are eager to understand if accreditation is truly a predictor of better health outcomes. This study demonstrates an association between accreditation and community health outcomes. Future research opportunities should validate these findings and further explore other community health outcomes from public health accreditation. Additional research opportunities include creating and validating a national data set that includes at a minimum public health department accreditation status, FIPS codes, and state public health governance structure. Linking this database to key variables in the National Association of County and City Health Officials and Association of State and Territorial Health Officials profiles of local and state/territorial health departments respectively would standardize and streamline these future research efforts.

Implications for Policy & Practice

- Previous research has demonstrated that accredited LHDs have enhanced capability and capacity to address various threats and hazards. The results of this study demonstrate an association between LHD accreditation and improved community health outcomes.
- Other factors that were associated with community health outcomes included the state policy environment and public health infrastructure as well as CCVI. Future research should continue to examine the relationship between these factors and accreditation.

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PHAB

National Public Health Accreditation: Now Is the Time

Paul Kuehnert, DNP, RN, CPH, FAAN; Kaye Bender, PhD, RN, FAAN

Inquiring minds want to know: what is the value and impact of public health accreditation? The three impact evaluation studies featured in the special section of this issue of the *Journal of Public Health Management and Practice* provide some long-awaited answers to this central question. We encourage you to read them thoroughly, and to do so in the context of the vision we all share for a robust and modern public health system now and into the future.

Davis et al[1] get right to the heart of the matter with their retrospective cohort study that took advantage of the naturally occurring experiment created by the COVID-19 pandemic response in the United States from 2020 to 2022. Examining critical population health markers across all 3000 US counties over 4 distinct points in time during the pandemic they found that communities served by nationally accredited local health departments had significantly higher adult COVID-19 vaccination rates and significantly lower COVID-19 mortality rates concluding:

> While it is important to demonstrate that the process of accreditation can lead to improvements in capacities and capabilities and improve quality, policy makers and the public are eager to understand if accreditation is truly a predictor of better health outcomes. This study demonstrates an association between accreditation and community health outcomes. (Davis et al, p. 163.)

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The authors appreciate comments from Amy Belflower Thomas on an early draft of this commentary. Publication fees for this special section were funded by the Robert Wood Johnson Foundation (Grant Number 79215) and the evaluation work was funded by the Centers for Disease Control and Prevention (Grant Number NU90TO0000002).

Dr Kuehnert is the current President and CEO and Dr Bender is the past President and CEO of the Public Health Accreditation Board.

The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002099

Rightly, Davis et al are clear about the limitations of their study, chief among them being that even very significant levels of association do not prove causation. But this robust examination of US COVID19 public health response and the dramatic, positive association of Public Health Accreditation Board (PHAB) accreditation with better population health outcomes is consistent with earlier studies[2-4]and numerous anecdotal reports from the field.[5]

The other two accreditation impact studies featured in this special section explore additional aspects of the value and impact of PHAB accreditation by using both qualitative and quantitative methods to interrogate the experiences of small and Tribal health departments[6] as well as the experiences of local health departments, the state health department, and state policymakers involved in the implementation of Ohio's statewide mandate for PHAB accreditation.[7] Each of these studies identify that a principal impact of accreditation is the diffusion of quality improvement knowledge, tools, techniques, and capabilities across the public health department resulting in a measurable shift in organizational culture to one that is unified around mission and dedicated to continuous improvement for the benefit of community residents. Another key impact highlighted by both studies is the increased number, type, and effectiveness of partnerships with other sectors – especially, but not only, health care – to address community health needs. In turn, participants in these two studies also identify that their accreditation enhanced their communication effectiveness, their engagement with diverse community members and leaders to address disparate health outcomes, and the pride their staff felt in their work and their identity as public health professionals.

When PHAB was established in 2007 and the voluntary accreditation of US health departments was initially started in 2009 through development and *beta* testing of national, evidence-based standards, the purpose was to incentivize health departments to adopt quality improvement and performance management systems (previously not common in public health practice) to improve accountability and performance of those health departments. Much of the technical assistance

provided to health departments preparing for accreditation centered around a systems approach to quality improvement, performance management, emergency preparedness, communications, education, workforce development, and planning- all with evaluation and data driving decisions and changes to those systems.

Studies[8,9] in the early years of the uptake of accreditation pointed to the impact of going through the accreditation process as the primary benefit of becoming nationally accredited. The process was specifically designed to focus on the essential services of public health, grounded in a culture of quality. Health departments received the beneficial optics of being nationally accredited, but they also became learning organizations focused on using data and feedback to improve their system, their partnerships, and their authentic work on equity. The voluntary nature of accreditation meant that health departments chose to go through this process for their own benefit and that of the communities they serve. Over time, as health departments have become more adept at the processes associated with measuring their performance, the perceived needs for an external process, like accreditation, raises questions again about its value and impact.

The COVID-19 pandemic experience in the United States and around the globe has led to a renewed sense of urgency to assure that all people everywhere enjoy the benefits of robust public health services that protect and promote health and prevent disease. Accelerated efforts to identify, clarify and operationalize essential public health functions[10] by the World Health Organization and foundational public health services and capabilities[11] by the US Centers for Disease Control and Prevention are fully underway. Significant new funding and technical assistance and training resources[12] have been made available since late 2022 to assure their delivery to communities and their residents across the United States. The studies published in this special section provide early evidence of the value and impact of investments in public health infrastructure. This foundational evidence must be broadened, deepened, and built upon to secure sustained investments in public health infrastructure.

National public health accreditation is key to growing and sustaining public health capabilities and services. Accreditation provides transparency and accountability to the public – an absolute necessity to securing policymaker support for sustaining the resource investments needed over the long run. And, accreditation does more than provide an external check for conformity with standards. Its true value and impact are found in building organizational cultures in health departments that are resilient, dedicated to continuous quality improvement, and fully engaged with community members and partners.

It is not enough to assert that your health department is "high performing." Being able to externally demonstrate that claim through a peer-reviewed process against national, evidence-based standards is more essential than ever. There is no better time than now to begin – or continue – your health department's journey to earning national public health accreditation.

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Research Full Report

PHAB

Perspectives on Public Health Department Accreditation: Lessons Learned From Ohio's Accreditation Mandate

Tonni Oberly, PhD, MPH; Simone R. Singh, PhD; Amy Bush Stevens, MSW, MPH; Robin Blair-Ackison, MPH; Anna Sheeran, MSW, MPA; Britt Lang, MA, MPH

ABSTRACT

Context: Ohio is the only state that requires local health departments (LHDs) to be accredited by the Public Health Accreditation Board (PHAB). As of May 2024, 80% of Ohio's 111 LHDs achieved accreditation, making Ohio the state with the highest proportion of accredited LHDs in the country.

Objectives: This study examined the experience of public health accreditation in Ohio including the perceived value of PHAB accreditation for LHDs. It also explored the extent to which perspectives on the value of mandatory accreditation differed between state and local health officials.

Design: Data for this study was obtained from 5 focus group interviews with 41 participants, representing state and local perspectives on PHAB accreditation in Ohio. Interviews were recorded, transcribed, and coded using inductive and deductive coding for a thematic analysis.

Results: Focus group participants outlined numerous advantages that accreditation has brought to their organizations. Commonly cited benefits include enhancements in quality improvement and performance management, strengthened collaborations and partnerships, improved communications, and optimized resource use. Challenges in achieving accreditation involved the financial expenses associated with the process and constraints on staffing resources. State officials generally expressed positive views on the accreditation mandate, perceiving it as a pathway to modernize the public health system and ensure consistency in service delivery across communities. In contrast, local stakeholders offered more nuanced perspectives and voiced concerns about the intentions behind the mandate.

Conclusions: The experience of health officials in Ohio offers lessons for both PHAB and officials in other states working to increase public health department accreditation levels. Successful implementation of accreditation mandates requires trust between state and local partners, open communication, and clarity of purpose. Moreover, attaining accreditation necessitates substantial resources, including technical assistance, financial support, and a robust workforce.

KEY WORDS: accreditation mandate, local health departments, Ohio, public health accreditation board (PHAB), state health department

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Support for this work is provided by the Public Health Accreditation Board (PHAB), through funding from the Centers for Disease Control and Prevention (CDC) under Grant Number NU90TO0000002.

The authors thank the many Ohio public health stakeholders who contributed to this project through focus groups and key informant interviews, as well as by providing feedback on study design and the final report. The Association of Ohio Health Commissioners (AOHC) and the Ohio Department of Health assisted with focus group recruitment. The authors and PHAB also appreciate review and feedback on methodology by the PHAB Research Advisory Council.

As this was an evaluation, this work was not reviewed by an Institutional Review Board. However, the work followed standard practice in the field and informed consent was obtained for all participants.

This study was funded by PHAB through a contract with HPIO in response to a competitive request for proposals.

Since 2011, public health departments in the United States have had the opportunity to pursue accreditation from the Public Health Accreditation Board (PHAB). While accreditation is generally not required for public health departments, by voluntarily undergoing this process, departments demonstrate that they meet PHAB's standards and are committed to continuously improving quality, accountability, and performance of their public

The authors declare no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002094

health system and services. Accreditation thus can potentially play a crucial role in advancing the efficacy and efficiency of public health departments as they work to protect and improve the health of the communities across the country. As of August 2024, 42 state, 393 local, 6 Tribal health departments, and 1 integrated public health department system across the United States had achieved PHAB accreditation.[1]

Prior research on the value of public health department accreditation has shown that pursuing PHAB accreditation frequently stimulates public health department quality improvement and performance management activities.[2,3] Quality improvement consistently emerges as a leading incentive for seeking accreditation, and it stands out as one of the most frequently mentioned benefits.[4] Accreditation has also been shown to enhance relationships with community partners, which enables public health departments to expand their services and engage more partners in service delivery.[5-7] Furthermore, accreditation is cited as enhancing accountability of public health departments and thus improving visibility and credibility within their communities.[8] Finally, accreditation has allowed many public health departments to improve their resource utilization and bolstered their competitiveness for funding opportunities.[8]

Research also highlights challenges related to achieving public health accreditation. The literature largely focuses on the barriers faced by small and rural local health departments (LHDs). Rural and small LHDs often lack the necessary resources for pursuing accreditation including staff, time, and financial resources.[9-13] These challenges highlight the difficulties that agencies encounter in meeting the standards set by PHAB.

Ohio is the only state that requires local health department accreditation and is therefore the state with the highest percentage of LHDs that have achieved PHAB accreditation (as of May 2024). Between 2013 and 2021, state policymakers have used several policy levers to advance accreditation. Initial legislation in 2013 granted the Ohio Director of Health the authority to require all LHDs to apply for accreditation by 2018 and to become accredited by 2020 (Ohio Revised Code 3701.342, effective 2013) as a precondition for receiving funding from the Ohio Department of Health.[14] Additionally, the Ohio Revised Code requires local health departments to report on accreditation preparation and application efforts (OAC 3701-36-03 as authorized by ORC 3701.342, adopted in 2013 and 2014).[15,14] Over the past decade, Ohio Department of Health leadership has clearly communicated the expectation that all LHDs become accredited. Legislation passed in 2021 exempts city LHDs with a population less than 50 000 from a consolidation assessment if they achieve accreditation by December 31, 2025. As of early 2024, 80% of the 111 LHDs in Ohio were accredited. All but one LHD is in the process of seeking accreditation as of May 2024. This unique political context positions Ohio to be a valuable case study in the accreditation process.

In 2023, PHAB contracted with the Health Policy Institute of Ohio (HPIO) to conduct an evaluation study to gain a better understanding of how accreditation has been implemented in Ohio and what Ohio's experience with accreditation can teach PHAB and other states. As a state with many urban and rural health departments, and with gradual adoption of accreditation over the past decade, Ohio provides a rich opportunity to explore the impact of accreditation on different types of local health departments. While Ohio's mandate is unique, the high volume of accredited health departments makes it an ideal case study to learn about implementation challenges and options for strengthening the positive effects of the accreditation process going forward. This paper presents key findings from the commissioned evaluation. Specifically, the paper addresses the following 2 research questions: (1) What are the perceived benefits of and barriers to PHAB accreditation for LHDs in Ohio? (2) How do state and local stakeholders perceive the value of the accreditation mandate?

Methods

Participant recruitment

Participants were recruited via email using a purposive sampling structure to recruit state-level government leadership representatives and representatives of statewide public health associations and universities. At the local level, the team used a stratified random sample to recruit local health officials to ensure representation across county type, region, population size, and racial demographics served. Focus groups were limited to a maximum of 9 participants due to funder restrictions. Table 1 outlines the sampling strategies used for each focus group type.

Data collection

Data for this study was obtained from 5 focus groups with 41 participants representing state and local perspectives on PHAB accreditation in Ohio. The first focus group included 7 current and former state

TABLE 1
Sampling Strategy by Focus Group Type

Focus Group	Sampling
State level	**Key stakeholders familiar with accreditation and the public health system**
1. State government leadership 2. Representatives of statewide public health associations and universities	Purposive sample: HPIO developed a sampling frame of current representatives from the Ohio Department of Health (ODH), statewide public health associations and Ohio universities. The list also included former state leadership involved in the 2013 legislation requiring accreditation. HPIO invited key public health advisors to provide input on the list. The final list included 9 top-priority participants for each group, as well as a back-up list of at least 5 potential participants per group.
Local level (LHDs)	**Local health commissioners or other high-level local health department staff**
3. Early adopters accredited (and/or re-accredited) (2013-2017) 4. Accredited later (2018-2023) 5. Not currently accredited	Stratified random sample: HPIO constructed a sampling frame from the list of PHAB-accredited LHDs from the PHAB website, as well as a list of current LHDs from ODH. HPIO stratified the sample by county characteristics including county type, region, population size and racial demographics, ensuring that representatives of LHDs in Appalachian and rural counties and LHDs that serve marginalized communities of color were included. HPIO used a random number generator to select 9 top-priority recruits and 5 back-up recruits for each group, balanced across stratified categories.

policy makers, including leaders in the executive and legislative branches who were in office during the development and implementation of the accreditation mandate. The second focus group included 8 representatives from state organizations and public health associations affiliated with the accreditation process. The final 3 focus groups featured health commissioners from local health departments that were early or later adopters and health departments that were not yet accredited (Table 2).

All focus groups were conducted via Zoom in January 2024 and were facilitated by a staff person and consultant representing the Health Policy Institute of Ohio. No one besides participants and researchers was present. Participant demographic information was not collected. Each focus group lasted approximately 90 minutes. Focus group conversations were recorded and transcribed using the transcription tool in Microsoft Word. Transcripts were then reviewed and edited for accuracy and clarity by researchers with reference to the Zoom recording.

Data analysis

All transcripts were coded in Microsoft Excel by one study author using inductive and deductive coding for a thematic analysis. Deductive coding was based on PHAB's Public Health Department Accreditation System Logic Model.[16] This framework illustrates how resources, or inputs in the accreditation system, along with strategies, can result in improved outcomes for PHAB, participating health departments, and the broader public health system. Key outcomes coded for included increased consistency in practice, increased interagency and cross-sector collaboration, increased health equity, and increased capacity for optimal investment in public health.

Researchers developed themes by categorizing responses by research question, assigning content codes and content properties (positive, negative, mixed or neutral), and then grouping codes into broader inductive and deductive themes. The team leveraged components from the COnsolidated criteria for REporting Qualitative research (COREQ) Checklist[17] as well as member checking to report and verify the findings. Focus group participants were given an opportunity to review a draft of a comprehensive report which included the findings presented here, as well as

TABLE 2
Composition of Focus Groups

Focus Group	Number of Participants
State level	
1. State government leadership	8
2. Representatives of statewide public health associations and universities	9
Local level	
3. Health commissioners (or designates) of LHDs that were early adopters of accreditation (initial accreditation in 2013-2017)	8
4. Health commissioners (or designates) of LHDs that were accredited later (initial accreditation in 2018-2023)	7
5. Health commissioners (or designates) of LHDs not currently accredited	9

additional analysis of secondary quantitative data used for the broader evaluation. Researchers elicited and responded to feedback on the accuracy and meaningfulness of findings, including focus group themes.

Results

Overarching themes from the focus groups include both the benefits and barriers of PHAB accreditation and differences in state and local level perceptions of the accreditation mandate. See Table 3 for a summary of themes and subthemes.

Benefits of PHAB accreditation for LHDs in Ohio

Performance management and quality improvement

Focus group participants described many ways that accreditation has benefited their organizations. The most frequently mentioned benefits to health departments included quality improvement and performance management; collaboration and partner relationships; and improved communication strategies. Focus group participants felt particularly strongly about the advancements in quality improvement and performance management practices because of accreditation, as exemplified in the following quote:

> I think we truly do strive for continuous quality improvement, and I think PHAB has really pushed us towards that mindset. I think that's probably the biggest success we have had out of accreditation in various health departments is just that mindset of are we doing things the most efficient way? Are they effective? How can we improve them both internally and externally? So, I think that's the biggest advantage that we've seen come from [accreditation]. (Early adopter LHD focus group)

Collaboration and partnerships

Respondents' perceptions of the impact of accreditation on collaboration and partner relationships were somewhat more nuanced. Some felt that the accreditation process made partnership more cumbersome.

TABLE 3
Summary of Themes

Theme	Subtheme	Description
Benefits of PHAB accreditation	Performance management and quality improvement	LHDs described increased use of performance management and quality improvement practices as a result of pursuing and achieving accreditation
	Collaboration and partnerships	While some LHD representatives found the PHAB requirements for collaboration cumbersome to already existing partnerships, others saw accreditation as an opportunity to strengthen community partnerships.
	Communication strategies	LHDs described improvements to their communication strategies including branding and consistent messaging.
	Efficient use of resources	LHDs described improvements in the efficient use of resources through the standardization of processes.
Barriers to PHAB accreditation	Financial cost and staff resources	LHDs described financial costs and staff time as challenges to achieving accreditation. This was especially true among smaller LHDs.
	Administrative tasks	LHDs described some of the required administrative tasks as busy work that burdened staff time and resources.
Differences in state and local level perceptions of mandatory PHAB accreditation	Public health system modernization	State leaders saw accreditation as a strategy to modernize Ohio's public health system.
	Consistency across health departments	State leaders saw accreditation as a way to ensure consistent and equitable services across the state. On the other hand, LHDs from predominantly white areas of the state often felt that the equity components of accreditation were not relevant to their communities.
	Mandate motives	LHDs questioned state motives for the accreditation mandate. This was especially pronounced among small LHDs who perceived the mandate as a strategy to force consolidation of health departments.

On the other hand, several focus group participants stated that they had good relationships with external partners prior to pursuing PHAB accreditation but that the accreditation process may have encouraged them to strengthen them further:

> Some [LHDs] already had good relationships prior to the accreditation requirement, with their cross-sector partners, with their county elected officials, with their county commissioners. But with accreditation, it kind of pushes [more collaboration], and that's a requirement that you have that community engagement, whether it's faith-based groups, other governmental agencies, but also the Chamber of Commerce, other regulated entities... So, I think, certainly, accreditation helps with [collaboration], because it's one of the requirements that you have that engagement and cross-sector collaboration. So, absolutely it helped. (State government leadership focus group)

Some respondents noted that the COVID-19 pandemic also led to improved community partnerships, making it difficult to isolate the impact of accreditation from those of the pandemic, especially for LHDs that became accredited right before or during the pandemic.

> I will say that our partnerships were lukewarm before COVID. I will say that during the COVID pandemic is when we really strengthened our partnership with our community and then we were able to continue and maintain that positive partnership through PHAB and then with the different committees with the CHA/CHIP (community health assessment/community health improvement plan). It's hard to say whether PHAB helped us to ignite that partnership, but it definitely helped us to strengthen that partnership we have with them now. (Not currently accredited focus group [in accreditation process])

Communication strategies

Improvements to communication strategies were another notable theme for LHDs. Respondents expressed that the accreditation process prompted them to adopt a more comprehensive and professional approach to communications, including the use of branding strategies and consistent messaging.

> We are doing better at communicating who we are, what we do, why we do the things that we do. ... We're pushing ourselves to be more visible. So, I think that that's something that's a benefit of PHAB. (Not currently accredited focus group [in accreditation process])

Efficient use of resources

Focus group participants emphasized that the standardization of policies, practices, and documents required by accreditation has resulted in more efficient and effective use of resources. Participants provided examples of how standardization helped save staff time by "not reinventing the wheel," provided continuity during times of high staff turnover, and supported peer-to-peer assistance and staff sharing between and within LHDs.

> So, it really helps standardize that process for whether it was writing grants or if we're just starting a new program, what are the minimum standards that is required and making sure that that's consistent across all departments. So that new way of thinking and that new established standard was very helpful. (Later adopters LHD focus group)

Barriers to PHAB accreditation for LHDs in Ohio

Financial cost and staff resources

LHDs also described several barriers and challenges faced during the accreditation process. The leading challenge described was the financial cost of accreditation. Costs described by the local health departments included the required PHAB fees and additional costs incurred by some departments including the elective cost of hiring consultants and completing pre-requisite activities including collecting or purchasing data for a community health assessment (CHA). Staff time was an especially notable cost for smaller LHDs who often noted that the current one-size fits all model seemed unreasonable and suggested that there be different expectations for smaller LHDs:

> We have eight [staff] people. And we did the same amount of work that a very large department [would do] .... We did the same amount of work that county health departments did with eight people. So...it's not fair that we had to do the same amount of work with less number of people. I'm pretty darn proud that we did the same amount of work as departments that have entire staff devoted to accreditation. (Not currently accredited focus group [in accreditation process])

Burdensome administrative tasks

Respondents also described some of the required tasks as "busy work" that added little value and were thus seen as an unnecessary burden given limited staff time and resources:

> [I am] really emphasizing the cost of doing the busy work... Some of these other elements that you are required to do, that for your health department have little value beyond the fact it's required for PHAB. That's an expense that I could really live without, even more so than the cost of the annual fee I could do without in terms of staff time, staff resources, etc. (Early adopter LHD focus group)

Differences in the perceived value of mandatory PHAB accreditation between stakeholders at the state and local levels

Notably, thematic differences between early, later, and non-accredited health departments did not arise. However, distinct themes emerged between state and local health officials regarding the advantages and drawbacks of mandatory PHAB accreditation. In general, state officials expressed predominantly positive views on the accreditation mandate, whereas local leaders shared more varied and nuanced perspectives on the mandate.

Public health system modernization

State officials viewed accreditation as a means to modernize the public health system and sought alignment across the state health department, governor, and legislature in the development and implementation of the mandate:

> Frankly, I'm convinced that we did the right thing... Call me Pollyanna, but I think we're in a much better place, and I think we will continue to be in a better place because of accreditation. So, did things happen correctly in 2012? Yes, they did. It's a great day for public health in Ohio. (State government leadership focus group)

Consistency across health departments

From the state-level perspective, accreditation was especially important to drive consistency across the state by guaranteeing that all health departments, no matter their size or geographic location, could provide quality services to their communities:

> From the administration standpoint, it was a real opportunity just to make sure wherever you were in the state, you knew your public health district had enough capacity to be able to get the job done. (State government leadership focus group)

Consistency was described as laying the foundation for increased capacity for optimal investments in public health. State leaders described a vision for how universal adoption of PHAB accreditation positions local public health to receive increased investments from the state legislature, hospitals, Medicaid and other partners who will "know what they are buying:"

> ...speaking as a legislator at that time [when the mandate was established], there was always a desire to fund public health a little more meaningfully out of the General Revenue Fund... [We were] trying to find a more universal platform that the state might actually be able to fund... across the state in a more equitable universe. (State government leadership focus group)

Achieving consistency across the state was also framed as an equity issue. State policymakers viewed accreditation as a way to guarantee the equitable distribution of public health resources across the state:

> I think accreditation really homes in now on equity, and it will ensure equity, because you're going to get similar services and similar resources from your health department no matter where you live in Ohio. (State government leadership focus group)

On the other hand, LHD representatives from predominantly white areas of the state often viewed the equity components of PHAB accreditation as unnecessary or irrelevant. For example, one focus group participant stated:

> I am at a very white Caucasian populated community and trying to meet these requirements and to accommodate [when] we have less than 1% of Black African Americans... How do I spread some of those things across out there? What essentially I feel like create an issue that doesn't even exist. I think that's very challenging for us as we move forward... But you know, domain four focused a lot on that under 1.5[%] and we were essentially creating these issues that didn't exist to solve a problem we didn't even have. (Not currently accredited focus group [in accreditation process])

Mandate motives

Local health officials had a more mixed view of the perceived motives surrounding Ohio's accreditation mandate. While local health officials understood the benefits of accreditation, there was an underlying doubt and questioning of the state's motives for the accreditation mandate. This skepticism was particularly pronounced among smaller departments, which perceived the mandate as an attempt to compel them to merge with larger counterparts:

> The mandate in Ohio was never about quality improvement, although it's a great sound bite. It was really a backhanded way to force consolidation and regionalization. (Later adopters LHD focus group)

State policymakers were cognizant of the local perception regarding accreditation as a consolidation strategy, yet they firmly asserted their vision of accreditation as a mechanism to ensure consistent service provision. However, this perspective was nuanced, as state leaders also acknowledged that if smaller local health departments were unable to meet accreditation standards, collaboration through mergers or resource sharing might be necessary:

> I know a lot of local health departments may perceive that as a way of forcing mergers or consolidation among them, but I think that we were totally supportive, at the state level, of 'hey, if you're a small health department and you provide good service and quality service to your residents and you can achieve accreditation, keep going.' But if you're not, and you can't provide quality services, maybe you should consider combining with the county health department in your county... There are a lot of advantages of combining, but I don't think accreditation was ever designed as a tool to push mergers or consolidation. (State government leadership focus group)

Discussion

Our research highlights differences in perspectives across state and local level public health officials regarding the public health accreditation mandate. The experience of health officials in Ohio offers lessons for both PHAB and officials in other states when considering public health accreditation mandates. For example, successfully implementing accreditation mandates requires trust between state and local public health partners, open communication, and clarity of purpose. Clear and mutual understanding of the purpose of the mandate is essential, ensuring that state and local partners are aligned in their objectives and expectations. This clarity helps mitigate potential misunderstandings and fosters a sense of shared purpose, driving efforts toward achieving accreditation goals effectively and efficiently.

Additionally, achieving accreditation requires significant resources including technical assistance, financial support, and a robust workforce. Both state and local health officials acknowledged the substantial costs to health departments of pursuing PHAB accreditation. To support health departments in these efforts, states should develop a robust infrastructure for training, technical assistance, and peer-to-peer sharing. Learning communities and document templates are valuable tools to assist local health departments, especially small departments, in achieving accreditation.[13] In addition, states should integrate accreditation-process-related skills into their public health workforce development efforts. The need for state funding to support the public health

Implications for Policy & Practice

- Ohio's accreditation mandate has resulted in high rates of accreditation among LHDs. As of May 2024, 80% of the 111 LHDs in Ohio were accredited, making it the state with the highest proportion of accredited health departments.
- Accreditation provides key benefits, including standardization of processes, enhancements in quality improvement and performance management, strengthened collaborations and partnerships, improved communication, and optimized resource use. However, barriers to accreditation—particularly financial expenses associated with the process and constraints on staffing resources—can be substantial, particularly for smaller health departments.
- Accreditation promotes a strong focus on equity, but more guidance is needed to help health departments understand the many ways that they can work toward more equitable communities.
- The staff time required to pursue accreditation is significant and involves some administrative activities that LHDs perceive as not resulting in meaningful change or, worse, crowding out more constructive activities. Future versions of the PHAB standards and measures should be informed by research and practice-based evidence that assesses the meaningfulness, utility and expected outcome of each standard and measure.
- States considering an accreditation mandate should build trust with LHDs to ensure transparent communication and aligned goals.

workforce will likely increase in the future, particularly when pandemic-era federal funding ends.

The research also highlights a perceived disconnect regarding the promotion of equity in the accreditation process. Accredited health departments frequently report that the accreditation process helped them to strengthen their approach to equity.[18,19] Yet, focus group participants often expressed ambiguity and frustration when striving to fulfill PHAB's accreditation criteria. Health departments, especially those in predominantly white or rural communities, may need additional guidance on defining and addressing issues associated with health equity.[15] States should consider providing training to help health departments understand the many ways that they can work toward more equitable communities, including activities tailored to engage and meet the needs of people of color, people with low incomes and disabilities, veterans, and immigrants, among others. Notably, PHAB's latest version (2022) has an equity-centered focus and was designed to meet concerns about ambiguity.

Limitations

The study has limitations that should be considered. First, study findings may be affected by voluntary participation bias. Although participants were recruited using either a purposive or stratified random sample approach, individuals who volunteered to participate may have had strong pre-existing opinions about PHAB accreditation and Ohio's accreditation mandate. Additionally, Appalachian LHDs were slightly overrepresented in the sample compared to the number of LHDs in Ohio and highly overrepresented relative to proportion of state population served. As a result, the views expressed in the evaluation may not be fully representative of opinions across Ohio. Similarly, interview participants were in leadership positions instead of frontline workers. It is possible that different perspectives surrounding accreditation would arise with engagement with people in frontline public health positions. Additionally, the findings are specific to Ohio. Therefore, while the study provides valuable insights, readers should exercise caution when generalizing these findings to other settings. Finally, while the perspectives of the public and partners of LHDs are important, these insights were beyond the scope of this project. Future research should engage with people served and partners to understand their perspectives of public health accreditation.

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PHAB

Reaccreditation and Pathways Recognition Experiences of Small Local and Tribal Health Departments

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ABSTRACT

Context: This paper describes experiences and views of leadership teams from 4 small local health departments (LHDs) seeking Public Health Accreditation Board (PHAB) reaccreditation or Pathways Recognition using PHAB Standards & Measures Version 2022. The Pathways program launched in 2022 provides additional supports for improvement of public health practice.

Objective: Given the need to accelerate accreditation among small health departments, the purpose of this study is to share small health departments' strategies for overcoming accreditation challenges and actionable advice for use by other health departments.

Design: In this descriptive qualitative study, the study team conducted 22 individual interviews with 4 small LHDs from January to March 2024.

Setting: Participating small health departments were located in the Midwestern and Western United States with staff sizes ranging from 3 to 47.

Participants: Interview participants included small health department leadership teams, a local board of health member, and a contracted external accreditation consultant.

Main Outcome Measures: We used a semi-structured interview guide to elicit participant experiences and views on accreditation processes, benefits, facilitators, strategies for overcoming challenges, and advice for other small health departments.

Results: Participants suggested that accreditation benefits far outweighed the challenges. Perceived benefits included improved organizational procedures, equitable delivery of needed effective programs and services, and enhanced public perception. Key strategies to overcome staff capacity challenges were establishing a team approach and orienting and mentoring new staff in the "why" and "how" of accreditation. Advice included learning what is involved, taking the time to lay a foundation beforehand, and not waiting for a perfect time as accreditation is about improvement, not perfection.

Conclusions: Small health departments can achieve and maintain PHAB accreditation by strategically implementing strategies to overcome staff capacity and other challenges. The Pathways Recognition program is a supportive option for small health departments wanting to improve public health practice.

KEY WORDS: accreditation, governmental public health, local health departments, Public Health Accreditation Board, tribal health departments

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P.A. was the principal investigator of the study. With P.A., M.F. co-led project design, interview guide development, thematic analyses, case narrative writing, and report development. P.A., M.F., and A.N.C. conducted interviews, qualitative data coding, and thematic analyses. P.C.E. and R.C.B. advised the study team on methods, data instrument development, and reports. B.L. and A.B.T. guided selection and recruitment of participating health departments, provided input, and edited case narratives. P.K. conceived of the initial study design and provided input. All authors provided intellectual content to the project and manuscript, provided critical edits on article drafts, and approved the final version of the manuscript. We thank the interview participants for their time and perspectives. We also thank Renee Parks, Senior Research Manager, for formatting support, and Mary Adams and Linda Dix for administrative support at the Prevention Research Center at Washington University in St. Louis.

This work was supported by the Public Health Accreditation Board through funding from the Centers for Disease Control and Prevention under Grant Number NU90TO000002. The Robert Wood Johnson Foundation provided funding for the special section under Grant ID 79215. Support was also received through the Centers for Disease Control and Prevention under Grant Number U48DP006395.

Ethical approval as an exempt study was obtained from the Institutional Review Board at Washington University in St. Louis on November 13, 2023 (identification no. 202310219).

The authors declare that they have no conflicts of interest.

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DOI: 10.1097/PHH.0000000000002084

Introduction

While many state and large city and county local governmental health departments experience the benefits of national accreditation through the Public Health Accreditation Board (PHAB),[1-5] proportionately fewer small health departments have sought PHAB accreditation.[6,7] Small health departments are defined as governmental health departments that serve fewer than 50 000 people. Small health departments comprise 62% of the 2512 local governmental health departments included in the 2022 National Profile of Local Health Departments and serve <10% of the US population, yet only 18% of responding small health departments were PHAB-accredited or applying for accreditation as of 2022.[8] While challenges and barriers to accreditation processes are common, small and rural health departments may experience challenges more acutely due to small staff sizes and competing priorities,[7] leading to the perception among many small and rural health departments that time and effort spent on accreditation may outweigh anticipated benefits.[9]

PHAB has taken several actions to support increased small health department participation. Actions have included: (1) gathering input from small health departments about challenges to applying for national accreditation through PHAB,[7,10] (2) listening to feedback from tribal health departments, (3) garnering recommendations from state health departments that support local health department (LHD) accreditation efforts, and (4) working with Centers for Disease Control and Prevention to support use of Public Health Infrastructure Grants to fund health departments to develop and implement plans deemed essential to health department performance and required in PHAB applications.

The Pathways Recognition program was launched in 2022; it is a program for local, tribal, and territorial health departments not yet ready for or interested in full accreditation to be assessed and recognized against a subset of the national accreditation standards.[11] Thirty-four measures from Version 2022 of the Standards & Measures that are centered around the Foundational Capabilities are assessed in the Pathways Recognition program. Measures are divided into 2 tracks: Services and Partnerships, and Health Department Systems. Health departments can choose to complete 1 or both tracks, although Pathways Recognition is only granted upon completion of both tracks.[11] Pathways Recognition is awarded at a point in time, vs accreditation that lasts for 5 years, so health departments can achieve Pathways Recognition knowing they are performing the Foundational Capabilities necessary to serve their community or use their efforts as a stepping-stone to full PHAB accreditation. Participating health departments are encouraged to join a Learning Community of Pathways health departments, where they can participate in peer learning and additional technical assistance opportunities.

LHDs report numerous benefits from PHAB accreditation. In NORC at the University of Chicago's 2013-2022 survey of PHAB-accredited health departments, 100% of the 47 responding small health departments reported the use of evidence-based practices increased with accreditation, compared to 70% of medium and 61% of large LHDs ($P < .001$).[1] A greater percentage of small health departments also reported improved staff competencies and increased partnering across multiple sectors,[1] consistent with other research.[3] Among all sizes of LHDs, frequently reported benefits included new quality improvement strategies implemented or planned (97%), improved operational or public health policies (92%), and improved capacity to provide high-quality programs and services (83%).[1] Earlier studies also found improved LHD performance[2] and increased quality improvement awareness, culture, and efforts following accreditation.[12,13]

Key benefits reported by reaccredited health departments of all sizes in the 2020-2022 PHAB Reaccreditation Survey included improved embedding of quality improvement in the health department culture (66%), "helped the health department use health equity as a lens for identifying and addressing health priorities" (66%, PHAB 2023, pg. 16), and increased internal departmental collaboration (58%).[14]

The purpose of this paper is to describe the experiences of small health departments using the PHAB Standards & Measures Version 2022 for reaccreditation or Pathways Recognition.

Methods

Overview

This is a descriptive qualitative study. Using a semi-structured interview guide, we remotely conducted 22 in-depth individual interviews with employees and affiliates of 4 small governmental health departments with jurisdiction populations <50 000. We elicited participant experiences and views on seeking PHAB Pathways Recognition or reaccreditation using the PHAB Standards & Measures Version 2022.[15,16] Topics included perceived benefits of national accreditation or recognition, facilitators, strategies for overcoming challenges, and advice for other small health

departments. Human subjects approval was obtained in November 2023 as an exempt study through the Institutional Review Board at Washington University in St. Louis (identification no. 202310219).

Recruitment

Health departments

Eligible health departments were county, district, or tribal health departments serving fewer than 50 000 people who were using PHAB Standards & Measures Version 2022 to seek Pathways Recognition, initial accreditation, or reaccreditation. From the 12 health departments eligible as of December 2023, the coauthors collaboratively selected 7 health departments to achieve diversity in health department type, region, rurality, and populations served. A PHAB coauthor extended initial invitations via email to the health department directors. One county LHD declined (a southeastern LHD with shared state and local governance seeking reaccreditation), and 2 county LHDs in the Pathways Recognition program did not respond to the emailed invitation (a rural western locally governed LHD and a decentralized northeastern LHD).

Individual participants

Eligible individuals were health department employees or affiliates at least 18 years old involved in national accreditation or reaccreditation preparations or Pathways Recognition. We purposively sampled managers and staff. Additionally, 3 governing body members and an external accreditation consultant were invited to interview. After a phone call with each director, the principal investigator extended an email invitation to 24 potential participants. Twenty-two agreed to participate via email or phone informed consent, and 2 did not respond.

Data collection

From January through March 2024, we conducted one 60-minute individual interview with each of 22 individuals. Three study team members conducted the interviews in teams of 2. Interviews were conducted via Zoom and audio recorded with permission.

Interview guide

We developed and pilot tested a semi-structured interview guide with 5 accreditation-involved employees from 3 local governmental health departments with jurisdictions slightly too large to be eligible for the current study and 1 state health department. We developed the interview guide based on our previous experiences working in and later collaborating with governmental health departments in practice-oriented research, prior studies of PHAB accreditation and evidence-based decision making,[17,18] research questions posed in the request for proposals, and published literature.[7] We revised the interview guide based on feedback from pilot participants, practice advisers to the Prevention Research Center at Washington University in St. Louis, and all coauthors. Topics included: experienced and anticipated benefits of national accreditation or Pathways; obtaining buy-in from governing bodies, leadership, and staff; facilitators and challenges; strategies used to overcome challenges; views on the PHAB Standards & Measures Version 2022, especially on the equity focus; successes along the way; and advice for other small health departments. The interview guide is available upon request.

Qualitative data analysis

Audio recordings were transcribed verbatim by Rev.com. An interviewer checked each audio recording against the transcript for accuracy and to remove identifiers. Deidentified transcripts were entered into NVivo Version 20 for data management and coding. The 3 coauthors who conducted the interviews developed a deductive codebook following methods outlined by Saldaña[19] and revised it based on pilot interview responses. The 3 coauthors independently coded the initial 2 interviews, revised the codebook, and recoded the initial transcripts. Pairs of interviewers then independently coded each deidentified transcript and met to reach consensus on codes. The 3 interviewers conducted thematic analyses, with pairs independently identifying themes and illustrative quotes for each topic and meeting to reach consensus on themes.[19-21] We followed the Standards for Reporting Qualitative Research[22] and the Consolidated Criteria for Reporting Qualitative Research Checklist.[23]

Results

Interview participants

Twenty-two small health department employees or affiliates from 4 small health departments participated in remote individual interviews. One small health department was a single county LHD, another LHD served multiple counties, and 2 were tribal. Three small health departments were pursuing PHAB reaccreditation; 1 was in the Pathways Recognition program. The interview duration averaged 55 minutes. Roles included health department directors, accreditation coordinators, leadership team

members, a local board of health member, and an external accreditation consultant. Of the 22 individual participants, 21 were women. Nineteen participants held a bachelor's degree; of these, 7 had a master's or doctorate degree. Three participants held a bachelor's or master's degree in public health. Other educational backgrounds included business, nursing, social work, nutrition, and exercise science. Participants had worked in public health 14.1 years on average, ranging from less <1 year to >30 years. For most, their entire public health career was at their current health department. Participants had been in their current positions an average of 5.6 years.

Perceived benefits of Public Health Accreditation Board accreditation or Pathways Recognition

Roadmap and accountability for excellence

Participants across health departments consistently stated that the PHAB Standards & Measures Version 2022 provided both a guide and accountability for excellence in public health practice. Participants found the internal review process helpful to identify strengths and areas for improvement to provide the best possible public health approaches to serve the community. Several participants stated that the accreditation processes led to more equitable, evidence-based, and culturally relevant programming, which in turn benefited the community, although they did not state which community health outcomes were improving. As one participant stated, "we're helping improve the positive outcomes of our community members." Participants from both tribal and non-tribal PHAB-accredited LHDs viewed reaccreditation as an opportunity to better integrate the Standards into their year-round work and to establish more efficient systems to document day-to-day efforts and improvement. Pursuing reaccreditation "gives us an opportunity to push our thinking … and be able to say we can actually do it better and we can be more effective."

> Re-accreditation, I feel like it's holding us accountable to that … superior level of public health. It's not just a one and done thing. We're maintaining that excellence that comes along with being accredited.

Improved public perception

Participants stated that being PHAB-accredited increased the credibility of the health department in the community and demonstrated that the health department was "living up to standards and science." National accreditation "confirms some of our values that are tied to our name" and showed "we're not just talk." PHAB accreditation was an opportunity to "tell our story" regarding programs, services, and successes.

Support for equity work

Participants in the 2 non-tribal health departments noted that their states had political climates and state agencies and bodies that made it difficult for LHDs to pursue diversity, inclusion, and equity both internally, such as in hiring practices, and in community programs and services. Participants expressed appreciation that they could lean on the equity Standards & Measures in Version 2022 to justify continued prioritization of serving vulnerable population groups. The 2 tribal health departments currently served historically traumatized and underserved tribal members and stated that the review process helped ensure they were providing equitable programs and services.

Promotion of inter-agency collaboration

Participants in 2 health departments further noted that the process promoted inter-agency collaboration, which also helped guide them to best serve the community. As one participant stated, "We've built a lot of very strong collaborations since being accredited."

Views on the new Public Health Accreditation Board Standards & Measures Version 2022

Public Health Accreditation Board supports for Pathways and reaccreditation

Several participants found the Ask PHAB platform helpful for feedback and learning, while others wished for greater PHAB supports during reaccreditation. Pathways participants expressed appreciation for the readily available support from a PHAB accreditation specialist. Pathways participants found it incredibly helpful to submit and receive feedback on measures throughout the process. It was also helpful to hear questions and answers during Pathways Learning Community sessions.

Positives and challenges in Version 2022

Table 1 summarizes what interview participants found helpful in Version 2022 and what was still difficult. Participants found the examples very helpful and the expanded scope of allowable documentation. Participants expressed relief that they could now use documentation from immunization, health care, and Special Supplemental Nutrition Program for Women, Infants, and Children programs. Participants appreciated PHAB's responsiveness to feedback from tribes. The most frequently mentioned challenge was the "high level of language" that remained in the new

TABLE 1
Views on Public Health Accreditation Board Standards & Measures Version 2022

Viewpoint	Illustrative Quote
Positives	
Guidance on documentation	"And what I really like about the Standards is they have really assisted us in the documentation piece."
Protection of institutional knowledge	"A lot of this is going to be able to be retained through the PHAB processes that have been put in place, and that we're not going to have to take too many steps backwards to get back to where we were if we would lose some people."
Clarity	"I would definitely say I think some of the Standards and Measures were easier to understand."
Examples very helpful	"The examples were definitely more clear and very beneficial."
Broader scope of allowable ways to meet measures	"I think allowing healthcare to be included as part of public health accreditation…because [for initial] we had great documentation that showed exactly what was being asked for, but it just happened to be in our sexual health clinic or our vaccine clinic or our home care services…so I think that's helpful."
Guidance on what was allowable was helpful	"I felt like there was just a lot more guidance and help as far as, oh, you could use this, or this could be included, which was nice."
Tribal flexibilities appreciated	"I know that PHAB is making an effort to cater more to Tribal health departments, recognizing that we are different, and our examples are going to be different. Our governance structures are going to be different. So I felt like they called out more of those 'Hey, for Tribal health departments, this would also be acceptable' because they understand that this is going to be different for Tribes."
Equity measures provide credibility for efforts	"And so I think the accreditation really lent us to be able to say, we're on the right path … and here are the Standards and Measures that show this is what a health department should be doing."
10 Domains align well	"We went from the 12 domains to 10 that better align with the 10 essential functions of public health. They've always aligned with that, but it makes more sense to have that matchup a little bit."
Increased narratives support descriptions of improvement, and progress	"So, I think the narrative allows health departments to focus more about being able to tell the story of their journey and the improvements they've made. And I really like that."
Challenges	
High level of language, so hard to discern what is asked	"Level of language that's in there can be very difficult for people to interpret sometimes."
Still a heavy lift	"So even though it's a few less measures, it still feels like it is a lot of work…from just purely a capacity standpoint, the Version 2022 didn't feel that much different, it still felt like a heavy lift."
Equity measures hard to meet	*For tribal health departments*: "We know our at-risk populations, but we don't have the data to demonstrate it the way we want to." *For local health departments*: "It was difficult with health equity just because of our political landscape."
Mismatch between health department's authority and what is asked	*Tribal health department*: "The governance is very different, I think. But I feel like we did a good job explaining that. I think it's important, you almost have to understand that to be able to move through the rest of the measures."

version of the Standards & Measures. For some measures, participants had difficulty discerning what was being asked. Also, both tribal and non-tribal small health departments experienced mismatches between the health department's governance and authority and some PHAB requirements, albeit different mismatches. Teams brainstormed creative extensive explanations to meet mismatched measures.

Facilitators for a smooth process

Team approach

Participants from each health department spoke of the importance of taking a team approach to accreditation. A team approach not only spread the workload among small staffs but facilitated staff learning and engagement. With staff learning and sharing of responsibilities came greater opportunities to ingrain the plans and Standards into ongoing year-round work.

Accreditation coordinator

Participants deemed it essential to have a designated staff accreditation coordinator spend part of their time on PHAB preparations year-round to spearhead efforts and keep teams on track. None of the participating health departments could afford a full-time accreditation coordinator. As submission dates drew nearer, accreditation coordinators spent a greater portion of

their time on PHAB-related work. Accreditation coordinators assumed numerous roles, including guiding team leads, setting up regular meetings, taking charge of the chosen electronic documentation system, keeping teams on track, communicating with PHAB, and submitting materials to PHAB.

Planning and documentation

Team leaders and accreditation coordinators also found it helpful to plan for initial accreditation or reaccreditation. The most consistently expressed sentiment was the importance of setting up a single documentation system everyone could use for performance management and as a repository for examples that might be used in application submissions. Participants also noted that following planning steps helped their processes: creating timelines, establishing a regular meeting schedule for leadership teams to discuss and monitor PHAB progress across domains, streamlining internal procedures, building PHAB content into new staff onboarding, and mentoring new staff.

Drawing on outside assistance from peer health departments and other sources also facilitated the process. Participants noted other health departments willingly provided advice, shared documents, and were happy to discuss how they met specific measures. Tribal health departments found the assistance they received from and gave to other tribal health departments and regional tribal networks the most helpful. Non-tribal health departments found networking through state associations of LHDs useful in requesting and receiving accreditation advice and tips. Two state health departments provided meetings or training on quality improvement that participants also found helpful.

Strategies for overcoming challenges

Staff capacity was the most challenging aspect of pursuing reaccreditation or Pathways Recognition. All 4 health departments lost over half their staff during the COVID-19 pandemic. Leadership teams remained mostly intact in 2 of the health departments. However, in the non-tribal small health departments in small towns and rural areas, new staff were also new to public health, further contributing to the challenge. Employees had multiple roles and competing priorities. Using a team approach helped to share the workload and provided a structure for experienced team leads and members to assist new team leads and members. Participants developed multiple ways to educate staff new to public health overall and to accreditation, including onboarding training sessions, one-on-one mentoring, drop-in question and answer sessions, regular meetings, and incentivized quizzes (Table 2).

The tribal public health departments had such different tribal governance and structures compared to county or district LHDs that it was often a challenge to describe how they met various measures. A team approach helped, as team members could together discern what was being asked and develop creative ways to meet the measures. However, consulting and brainstorming with other tribal health departments was most beneficial. Table 2 shows multiple strategies health departments used to demonstrate how they met the measures.

Several health departments changed their internal documentation processes for reaccreditation. They intentionally set up systems that they could also use to manage progress on plans, quality improvement, performance management, and other ongoing work. While one health department invested in Asana and Teams, others used Excel or other inexpensive software.

Advice from small health department participants

We asked each interview participant what advice they would give to other small health departments interested in PHAB accreditation or Pathways Recognition. Table 3 shows commonly mentioned responses across health departments. Some participants framed their advice regarding what helped their health department through the process: integrate the accreditation work with ongoing plans and processes; develop a team approach; ask peer agencies for help; and set up a documentation system and ways to organize the work. Others urged people to become familiar with the PHAB Standards & Measures beforehand so they can know what is expected, identify what aspects are ready, and plan for how they will address gaps. At the same time, participants advised others not to wait until a seemingly perfect time to start the process. They reiterated that the objective is "progress not perfection."

Discussion and Conclusion

In this descriptive qualitative study, individuals from 4 small health departments seeking reaccreditation or Pathways Recognition provided practical strategies for overcoming challenges and actionable advice for other LHDs.

Facilitators and advice to other health departments were largely similar to qualitative findings by Yeager and colleagues (2021) though the importance of creating a team approach was more strongly emphasized in the present study as an essential aspect.[7] Creating team approaches to accreditation preparations is strongly recommended by PHAB as a best

TABLE 2
Small Health Department Strategies to Overcome Accreditation Challenges

Challenge	Strategy	Illustrative quote
Staff capacity	Developed a team approach	"So we had a number of teams that worked on set criteria and all those teams had a lead that would get teams together to work on criteria together and then just make sure that that team was on track and making steady progress."
	Trained new staff in public health overall	"So they come out of college with degrees in varied fields, and then we have to train them on what public health is. And starting from square one of the history of public health to public health policy. What we're supposed to be doing, the essential public health services."
	Explained why and what of accreditation	"Helping them understand why it's important to ask these questions, do this process, document this way, that's just been part of their onboarding and folks are more comfortable with it."
	Developed PHAB orientation in new staff onboarding	"And we're still onboarding them, and they're still learning their roles in public health and understanding public health. And some of our staff that came in as COVID was winding down a little bit, they're still learning."
	Managers mentored new staff one-on-one	"So it just required the manager to spend more time with that person, more follow up meetings after the team meetings with PHAB, helping them understand what this is and the intent behind it."
	Planned to cross-train staff in future	"With the increase in staff turnover in the last decade, I think cross-training is critical…making sure that if anyone has an extended absence that is a part of one of our PHAB teams, or if our accreditation coordinator has a planned or unplanned absence, that we are better prepared to take that on."
Unclear how to meet measures given different tribal health department governance and structures	Wrote extensive narratives	"Sometimes we had to word things because we're so differently organized than a local health department. We would have to word things, really explain it. This is why we meet the measure because of our organization structure."
	Met with other tribes to identify how best to meet measures	"Those [meetings with Tribal health departments] have been instrumental because we are all facing the same kind of challenges being tribal nations and just bouncing those creative ideas off each other…so that has been a huge support."
	Teams brainstormed to discern what was asked and how to meet	"We meet monthly to discuss all the measures and are we meeting them, and we try to identify those examples."
	Found creative way to meet certain measures	"Question after question, we had to really think in a different way to answer it."
	Collaborated with other tribal departments	"We don't have an environmental health department in our health department. So that was one that we struggled with, which is why we brought in the sanitarian to be on our PHAB leadership team." "We have an MOU with the Environmental Division."
	Worked with PHAB to adjust examples	"We also noted that PHAB was quite flexible when it came to our annual reports as an example, because they allowed us to use COVID examples."
Lack of ongoing documentation system	Set up documentation tools and year-round processes	"Just continually checking in, checking on those documents, checking on all the things we said we're going to do, and just keeping us accountable all year long for the entire process. So then when it's time for reaccreditation, it's just that much easier."
	Saved examples as they happened	"So then in our PHAB folder that the team shares in each domain we would save backup examples and label them as which measure that they're meeting."
	Integrated accreditation documentation into day-to-day work	"We need a formal way to do this. And we did create a lot of policies off of initial accreditation. So those were in place for us when we went through reaccreditation in some of those gaps."

Abbreviation: PHAB, Public Health Accreditation Board.

practice.[24] Carman discussed the importance of teamship in preparing for accreditation, which Carman defined as such extensive teamwork that typical roles of leaders and staff by title or position are blurred so that those with expertise in different areas take on changing roles for accreditation.[25] In a review of LHD performance studies, researchers found that one of the characteristics of higher performing LHDs

TABLE 3
Overall Advice from Small Health Department Participants

Advice	Illustrative Quote
Use the process as a roadmap for excellence	"We're helping improve the positive outcomes of our community members. And really, for me, those are our greatest successes. That self-empowerment and that feeling of the work that we do matters, and then being able to see that in our community and seeing just our community flourish." "And you get all the benefits of providing that quality care evidence-based practice, culturally relevant practices, it incorporates it all. It's a guide. Even if you never go for accreditation, you can still use these Standards and Measures to guide you to improve programming."
Develop a team approach	"I think what works really well for us is that we've formed a core group of individuals that head up the plans and always come together. We meet very routinely monthly as a team and then quarterly in our different plans. I think sharing that workload, not just having one person in charge, but having a core team of people, I think that's worked really well for us."
Seek certain skills in an accreditation coordinator	"That's having an accreditation coordinator who is all in, organized, highly detailed, can work with people, understands the importance and value in this. That is so instrumental in becoming accredited." "And so just that ability to think critically and also that ability to focus, but then also communicate with others."
Learn what is involved beforehand	"I would definitely say review the Standards in depth. You don't have to understand every single thing, but you do have to understand what you're getting into. And that's a great way to see if you even want to attempt it. And I think take the path that's right for you."
Take your time	"And then only take biting off as much as you can chew at one time... So I think being thoughtful about it. And implementing change can be hard, and it needs to be thoughtful and well done, so don't rush it."
Plan ahead	"Give yourself time to determine your approach and capacity." "Meet often, schedule check-in meetings. Those are good lessons too, just to make sure that you stay on track. It kept us moving along, kept us accountable."
Ask peer agencies for help	"Rely on others who have already been accredited to help you...They were always willing to share a document, share advice, and share information on how they accomplished a measure."
Establish a documentation and organizational system	"Looking back, it's very evident that you need, ahead of time, to have a plan or a system in place for tracking and coordinating your staff and your documents." "If I could give one piece of advice it would be put in the time beforehand to make sure that your process is solid, because that is going to save you time, energy, and effort in the long run."
Utilize PHAB support	"But definitely keep track, utilize the Ask PHAB system, utilize the Pathways representatives for any questions that you may have, and follow their tips and tricks that they recommend doing throughout the program."
Don't let the "Perfect" get in the way of the "Good"	"And so, I think a piece of advice would be don't wait for the perfect time. The perfect time to get better is now, the perfect time to improve is now.... I understand you need the capacity too though, but I think it does add a lot of value into your work if you can pursue it."
Recognize the value	"Figure out a way to do accreditation; it's absolutely worth it. It's difficult; don't take it lightly, but I have no regrets because I completely see the value in accreditation and the value it instills in my staff to want to do the very best that they can for our organization and our community."
Communicate your successes	"The work is worth it to help you tell your story. I just think that is something that we don't always do well, and this is a way to do it."

Abbreviation: PHAB, Public Health Accreditation Board.

was leaders working with a team structure.[26] In the present study, the 3 LHDs seeking reaccreditation demonstrated teamship in their approaches, with each manager leading a different preparation team and managers and directors meeting regularly as a reaccreditation leadership team. Managers and directors discussed how valuable it was to work in teams set by matching expertise to the types of required plans and domain topics.

Seeking help from experienced LHDs was another important facilitator and recommendation for small health departments in both the present study and the study by Yeager and colleagues.[7] One LHD received support by participating in a statewide association of LHDs, while others culled examples and tips by contacting single LHDs. The 2 tribal health departments found it especially helpful to share ideas and experiences with other tribal health departments about meeting certain measures.

Additional advice shared by interview participants in our study and in the study by Yeager et al[7] included reviewing the Standards to understand what is involved, preparing a foundation ahead of time, and establishing an organized system of meetings and online document

management. Participants in the present study offered additional advice as well: take time to prepare but also "don't wait for the perfect time" since the process is about improvement, not perfection; identify existing staff or newly hired staff with a specific skill set to serve as accreditation coordinators; and utilize PHAB supports. While the time and effort involved are significant, participants in the present study urged others to embed the required plans and processes into the department's improved day-to-day operations and to apply for accreditation or Pathways Recognition because the benefits outweigh the challenges.

Staff capacity in small health departments is a common challenge to accreditation found in this study and earlier studies.[7,10] Staff capacity challenges in small health departments in the current study were due to staff turnover—which was greatly exacerbated during the COVID-19 pandemic—multiple roles of each employee, competing priorities, and difficulty hiring new staff with public health training or experience, especially in rural areas. A 2020-2022 survey of all reaccredited health departments shortly after receiving reaccreditation found that the most frequently reported challenges were limited staff time and staff turnover.[27] Key strategies regarding staff capacity expressed by participants in this study included creating a team approach, on-the-job training about public health in general plus specific accreditation onboarding orientations, and mentoring.

In describing the benefits of PHAB accreditation or recognition, participants emphasized the use of the PHAB Standards & Measures as a guide to excellence in provision of effective public health programs and services that were improving community health and improved public perception of the health departments. Participants stated that the accreditation processes led to improved quality and equity within their programs and services. Several participants also said that the improved programs and services benefited community residents but did not state which health outcomes were improving. Obtaining specific details regarding health outcomes is an outcome desired for future studies. In a survey conducted in 2020-2022 among health departments of all sizes and types that had been accredited for 4 years, half (51%) agreed with the statement "health department activities implemented as a result of being accredited have led to improved health outcomes in the community" (Siegfried et al., 2023, page 16). In open-ended responses to this survey, a few health departments credited more effective partnering to improve health outcomes.[27] One health department gave the example of addressing substance use disorder and breastfeeding rates in partnership with other agencies.[27] Other health departments noted difficulty attributing community health outcomes directly to accreditation.[27] Participants in both our study and the above survey noted that the accreditation process helped the health departments address health equity to improve community health.[27] Nearly half (46%) of participants in the Reaccreditation Survey in 2020-2022 agreed that the "population health outcomes reporting requirement led to greater emphasis on tracking health outcomes" (Siegfried et al., 2023, page 21)[27].

In sharing experiences with the PHAB Standards & Measures Version 2022, participants found the expanded examples and guidance helpful and appreciated that they could lean on the equity-centered 2022 PHAB Standards & Measures to justify their equity work to the public, stakeholders, and funders. Similarly, reaccredited health departments of all sizes and types reported that the reaccreditation process enhanced their health equity focus when setting priorities.[14]

In conclusion, small health departments pursuing PHAB reaccreditation or PHAB Pathways Recognition offer a wealth of practical strategies, experience, and advice useful to other small health departments. While findings cannot be generalized to all small health departments, other small health departments can build on the actionable recommendations from this set of small tribal and non-tribal health departments. Efforts to address the chronic underfunding of LHDs,[28,29] such as through Public Health Infrastructure Grant dollars, can be used to increase staff capacity to conduct health department planning and provide effective services to improve equitable community health.

Implications for Policy & Practice

- Small health department leadership teams in this qualitative inquiry deemed the benefits of PHAB accreditation or recognition far outweighed the challenges.
- Strategies to overcome staff capacity challenges included establishing a team approach, conducting an accreditation orientation, and mentoring of new staff.
- Participating small health departments used the PHAB Standards & Measures Version 2022 as a guide to improve organizational procedures and ensure provision of effective programs and services that best meet community needs.
- Participating small health departments seeking reaccreditation appreciated the enhanced public perception of the health departments following accreditation, including increased credibility and trust.

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Using National Public Health Accreditation to Explore Quality Improvement and Performance Management in Small Local Health Departments

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ABSTRACT

Context: This article focuses on 4 small local health departments (LHDs) that were in the process of seeking Public Health Accreditation Board (PHAB) reaccreditation or Pathways Recognition using PHAB Standards & Measures Version 2022.

Objective: The objective of this study was to explore the experiences of 4 small LHDs related to Quality Improvement (QI) and Performance Management (PM) in their pursuit of PHAB reaccreditation or Pathways Recognition.

Design: A team of researchers conducted 22 qualitative interviews with health department leaders and staff. Findings relative to QI/PM represent an embedded case study since they were part of a larger investigation.

Setting: The research team conducted interviews remotely with health departments located in the West and Midwest.

Participants: Participants included adults at least 18 years old and employed in 1 of 4 health departments.

Main Outcome Measures: Emergent themes from this qualitative investigation included using QI/PM tracking systems, building staff buy-in for QI/PM, integrating QI/PM into daily work, and advice for other health departments regarding QI/PM.

Results: Participants suggested that tracking systems helped them manage QI/PM processes. Staff buy-in for QI/PM was strengthened by building a sense of ownership of the process and connecting improvement processes to outcomes. Health departments integrated QI/PM into daily work by leadership modeling and communicating expectations. Advice for other health departments included finding a QI system that was easy to follow and recognizing the role of QI/PM in improving performance to better support the wellbeing of the community.

Conclusions: QI/PM are important tools for health department effectiveness. Participants affirmed that the primary purposes of QI/PM are to enhance internal processes and improve community health outcomes. Study findings demonstrate how 4 small health departments integrated QI/PM into their public health practice.

KEY WORDS: accreditation, local health department, performance management, public health accreditation board, quality improvement

Introduction

One of the most effective ways to advance the health of the population is to improve the performance management of governmental health departments.[1-3] DeAngelo et al[1] defined performance management as the strategic use of performance standards and measures, progress reports, and ongoing quality

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Justification for more than 6 authors: Peg Allen was the principal investigator of the study. With Dr Allen, Dr Matt Fifolt co-led project design, interview guide development, thematic analyses, case narrative writing, and report development. Drs Allen, Fifolt, and Mr. Crenshaw conducted interviews, qualitative data coding, and thematic analyses. Drs Paul C. Erwin and Ross C. Brownson advised the study team on methods, data instrument development, and reports. Britt Lang and Amy Belflower Thomas guided selection and recruitment of participating health departments, provided input throughout, and edited case narratives and reports.

The authors would like to thank all study participants. The authors also thank Renee Parks, Senior Research Manager, for formatting support, and Mary Adams and Linda Dix for administrative support at the Prevention Research Center at Washington University in St. Louis.

This work was supported by the Public Health Accreditation Board through funding from the Centers for Disease Control and Prevention under Grant Number NU90TO000002. Support was also received through the Centers for Disease Control and Prevention under Grant Number U48DP006395.

The authors declare they have no conflicts of interest.

Ethical approval for this research was obtained from the Institutional Review Board at Washington University St. Louis (Identification number 202310219).

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DOI: 10.1097/PHH.0000000000002062

improvement. As noted by the National Association of County and City Health Officials (NACCHO), performance management reveals gaps in performance, offers insight into unmet community and client needs and provides a data-driven approach to identifying and prioritizing quality improvement projects.[4]

In this paper, we describe the experiences of participants from 4 small local health departments (LHDs) in the United States (population jurisdiction ≤50,000) regarding quality improvement (QI) and performance management (PM). Disproportionately fewer small LHDs have sought PHAB accreditation as compared to state and large city and county local governmental health departments.[5,6] Three of the health departments were in the process of pursuing reaccreditation status from the Public Health Accreditation Board (PHAB); the fourth was in the final stages of participating in PHAB's Pathways Recognition program. All 4 health departments used PHAB Standards & Measures Version 2022. In the following section, we provide a brief history of performance standards as well as the performance management system for public health that led to a national set of recognized, practice-focused, and evidence-based standards through PHAB.

Background

In 1998, the Centers for Disease Control and Prevention (CDC) launched the National Public Health Performance Standards Program (NPHPS), which established national standards for state public health systems, local public health systems, and local governing bodies. These instruments were based on the 10 Essential Public Health Services (EPHS) developed in 1994; each instrument included standards and measures aligned to the EPHS and were intended to drive understanding of strengths and areas for improvement. In 1999, the Robert Wood Johnson Foundation partnered with the W.K. Kellogg Foundation to sponsor a national collaborative of public health practitioners to develop a performance management system for health departments, which resulted in The Turning Point Performance Management Model.[7] The NPHPS and The Turning Point Model laid the foundation for a national voluntary public health accreditation process in 2011 through the Public Health Accreditation Board (PHAB).

Public health accreditation board

The Public Health Accreditation Board (PHAB) was established as a 501(c)(3) organization that administers the national public health accreditation program and the Pathways Recognition program.[8] In 2022, PHAB released Standards & Measures Version 2022, which incorporates the 2020 revised EPHS,[9] embedded Foundational Competencies to promote accountability, and introduced the Pathways Recognition program.

Pathways Recognition is a program designed to support performance improvement efforts, strengthen infrastructure, and facilitate public health system transformation for local, Tribal, and territorial public health departments not yet ready to pursue full accreditation. Pathways can facilitate accreditation readiness for eligible health departments intending to use the program as a step toward accreditation. The Pathways Recognition program is a cohort-based model in which multiple health departments navigate the steps towards Pathways Recognition together through an optional but highly recommended Learning Community component. While there are some common elements between initial accreditation and Pathways Recognition, there are notable differences: (1) accreditation must be renewed every 5 years; Pathways Recognition is awarded on a singular occasion; (2) initial accreditation comprises 87 measures; Pathways Recognition comprises 34 foundational capability measures; and (3) the Pathways Recognition program does not include a site visit nor an action plan process.[10] Notably, QI/PM measures did not change with PHAB Standards & Measures Version 2022. Rather, this criterion was used for the purpose of LHD selection.

Quality improvement and performance management

QI represents one of the several performance assessment, planning, and improvement efforts under the umbrella of PM.[4] QI involves the deployment of process engineering techniques for the analysis, design, and ongoing implementation of public health processes to achieve measurable increases in health department performance and community outcomes. QI encourages (a) multidisciplinary teamwork, (b) empowerment so teams can make immediate process changes, (c) an iterative scientific approach to problem-solving, and (d) ongoing measurement and monitoring.[11]

Others have written extensively about QI and PM as related to PHAB accreditation. Past studies employed both quantitative and qualitative techniques, and topics are broad in scope, including the achievement of program goals[12,13]; accreditation readiness[14-16] formal mechanisms for evaluation[17,18]; gains in outcome measures[2,19]; acculturation of QI processes[20,21]; best practices and sustainability[22-25] and drivers and constraints.[25] Despite this comprehensive body of literature regarding QI and PM, little has been written on the subject over the past 5 years. The purpose of this paper was to qualitatively explore

small health department experiences with QI and PM through the lens of accreditation.

Methods

Selected health departments

The research team selected a convenience sample of 4 small LHDs whose jurisdiction populations were less than or equal to 50,000 to participate in the study. This selection process was facilitated by PHAB staff who had knowledge of small LHD engagement with accreditation. Since the larger study focused on the newest Standards & Measures, cases were selected to incorporate as many diverse perspectives as possible (eg, Tribal, multiple county service area). The size of health department staff ranged from 3 to 47, with employees in the largest of the 4 health departments also providing patient/client programs and services connected to community health needs. Two of the organizations are small Tribal health departments while the other 2 serve populations in a single county or in multiple counties. Two of the 4 health departments serve rural jurisdictions.

Population studied

Participants comprised employees representing small LHDs that used the PHAB Standards & Measures Version 2022 for national reaccreditation or Pathways Recognition. Participants were adults at least 18 years old and included the following roles: health department director, deputy director, other leadership team members, accreditation coordinator, equity coordinator, performance management, general staff, and local board of health members.

Data collection

This was a descriptive qualitative project. In spring 2024, the research team conducted individual remote interviews with 22 health department leaders and staff in 4 small LHDs that used the PHAB Standards & Measures Version 2022 to prepare for reaccreditation or Pathways Recognition. Interviews were guided by a semi-structured interview protocol, and researchers explored a range of topics; QI and PM comprised only one of multiple areas of inquiry. Therefore, this article can be considered an *embedded case study* which allowed us to explore a salient subunit of the larger study.[26] Key informant interviews lasted approximately 60 minutes and were audio recorded via Zoom. Audio recordings were transcribed verbatim by a third-party vendor. A team member checked each recording against the transcript for accuracy.

Data analysis

Two team members independently coded each interview transcript and came to agreement on codes. Pairs of team members then identified themes, conducted consensus theming, and prepared theme statements. Research team members used NVivo 20 to code, sort, and manage sections of text (QSR International Pty. Ltd., Version 20). Content coding followed procedures outlined by Saldaña.[27] Authors used deductive coding based on a structured codebook developed prior to interviews to explore key informant experiences with the PHAB Standards & Measures Version 2022. To ensure qualitative rigor, the research team followed the SRQR Standards for Reporting Qualitative Research,[28] COnsolidated criteria for REporting Qualitative research (COREQ) Checklist,[29] as well as multiple methods of verification (ie, peer debriefing, audit trail, author reflexivity).[30] All data were reviewed by co-authors, and disagreements were discussed until consensus was reached.

Ethical considerations

Institutional Review Board approval was received as an exempt study by Washington University in St. Louis (IRB-202310219). Participants gave verbal or emailed informed consent.

Results

In this section, we describe the results of our investigation regarding QI/PM among small LHDs that were in the process of pursuing reaccreditation status or Pathways Recognition. Four primary themes emerged from the data: (a) Using Quality Improvement and Performance Management Tracking Systems, (b) Building Staff Buy-in for QI/PM, (c) Integrating QI/PM into Daily Work, and (d) Advice for Other Health Departments Regarding QI/PM. We provide representative quotes to support each theme.

Using quality improvement and performance management tracking systems

Health department leaders and staff stated the PHAB QI and PM requirements stimulated improvement of formal QI and PM processes, including tracking systems. Consistent with common definitions in public health, participants differentiated PM and QI based on scope.[3] Individuals described PM as a system for tracking progress towards goals. QI, on the other hand, was seen as an effort to improve a specific aspect of a program or service.[4] The main barriers to QI and PM experienced by small health departments

were lack of time due to small staffs with employees fulfilling multiple roles, low staff capacity due to new staff also being new to public health, and difficulty obtaining staff buy-in for QI and PM. While LHDs participated in general accreditation collaboratives to address barriers, there was no mention of participation in QI-specific collaboratives.

Participants from all 4 health departments identified Plan-Do-Study-Act/Plan-Do-Check-Act (PDSA/PDCA) as the QI model they employed for process improvement. Several also mentioned tools and resources they used for tracking performance including Microsoft Excel, Microsoft Access, Asana, and Clear Impact. Only 1 individual mentioned the "Turning Point National Excellence Collaborative Framework," which developed the original PM system. They spoke about it from an historical perspective and suggested that it had been the "starting point" to a larger, integrated performance management plan for the health department.

One health department had recently invested in Asana at $600/month to help them organize, track, and manage their progress towards the PHAB Standards & Measures. The health department had integrated Asana with Microsoft Teams so that it could serve as their performance management system required for PHAB accreditation in addition to tracking accreditation goals. One participant observed that leadership was "willing to lean into not only paying for that [Asana] and figuring out how to pay for it but the changes of what it means to adopt new technology."

Several participants observed that purchasing tracking products such as Asana and Clear Impact may be out-of-reach for other small LHDs due to cost, which can be hundreds of dollars per user per year. However, they suggested that this investment in technology demonstrated the health department's commitment to program improvement. A key organizational leader indicated that their health department's investment in Asana was an effort to equip their employees with "the tools to work smarter, not harder," such as establishing timelines, setting reminders, and centralizing documents in 1 system.

Building staff buy-in for QI/PM

Participants indicated that staff buy-in to QI/PM was predicated on a commitment to the processes by health department leaders. Specifically, individuals observed that health department leaders were champions of QI/PM and committed to using results of improvement activities to enhance overall operations of the health department. In this way, leaders modeled their expectations for staff by understanding the purposes of QI/PM and incorporating these processes into daily activities, "It's an ongoing process, so it's continuous. So, make sure that you have that continuous buy-in." One individual stated, "your leadership team needs to be really good at QI and performance management. They need to understand it forwards and backwards to be able to make it just a part of every day." Another observed, "So, it really [is] having the buy-in from leadership. Even the director."

Staff ownership

Participants also observed that health department leaders encouraged staff ownership of the process by engaging individuals to identify improvement projects based on areas of greatest need or interest. Staff participated in QI and PM planning committees that rotated membership to increase staff involvement and frequently were engaged in supporting QI initiatives for the duration:

> So, we leave it to the staff to look at [their] programs and services and what do we want to improve on...And then it's really the staff that are leading that project and then seeing it out from the beginning all the way until the end.

To further support staff buy-in and understanding of QI/PM, participants from 1 health department said they included QI/PM training activities in their onboarding process for new employees:

> Quality improvement I think is something everybody knows a little bit about but doesn't [sic] necessarily know how to formally do it. And so, we do provide some training, and this is just training that we have developed over time. We have onboarding, we have them complete a performance management and a quality improvement training.

Understanding the why

Some participants recalled initial staff reticence to QI/PM but indicated that staff overcame their concerns when they saw how QI/PM could improve services for the community and make processes work better for them as well. According to participants, once staff made the connection between process and outcome, they more readily adopted the concepts of QI/PM,

> "Being able to see that because of the quality improvement efforts that we're doing, we are helping improve the experiences of our community members. We're helping improve the positive outcomes of our community members. I think there are so many benefits to becoming and maintaining accreditation from knowing we're serving our community to the best standards that we possibly can. We don't hit every piece of documentation fully 100%. But it's

that culture of continuous improvement, and trying to change the things we can change, so that we can better serve everybody in our community. That's huge alone."

"But PHAB and the different standards, they give us an opportunity to push our thinking and be able to say, Okay, what we're doing is working really well, but look, there's some other things that we can do that we can expand on this and we can actually do it better and we can be more effective."

Similarly, participants noted that QI/PM was more acceptable to staff when they understood the purposes of QI/PM. One participant stated, "quality is not pointing out something someone is doing wrong, quality is doing your job and constantly looking for ways to make it even better." In this way, health departments were committed to developing a "QI mindset." This mindset was best described as viewing all work through a quality improvement lens. Another participant underscored the iterative nature of QI/PM work by describing it as "progress, not perfection." Yet a third participant stated, "if you are not viewing your work from a quality improvement lens, you're really going to miss a lot of great opportunity."

Integrating QI/PM into daily work

Participants suggested that when QI/PM was done well, the processes became integrated into daily work, not only performed to meet PHAB requirements. One individual stated, "We live it, eat it, and breathe it...Quality improvement is just, it's an expectation in our department." Leaders and staff members described how and when QI/PM fit into the flow of the year, which included setting new performance management standards once a year and evaluating programs and services on a quarterly basis as required by PHAB, resulting in multiple QI projects per year. Additionally, in 1 LHD, "we require that each program have a QI project that they're working on, pretty much at all times."

For example, 1 LHD implemented a QI project to make the overwhelming number of well inspections more manageable and improve the flow and scheduling of inspections. Another LHD used a QI process to make their intake form language more understandable to clients, which led to more complete demographic information. This LHD also did QI projects to improve the flow of a vaccine billing form and to move to a different accounting system for improved efficiency. A third LHD applied QI to reassess use and communication between multiple transportation resources to better meet community transportation needs. This led to improved access to services and programs. "We have seen over and over again areas where...by going through the process and being able to identify areas where we could make small adjustments that made a huge impact in positive returns."

Consistent with their approach to addressing the PHAB Standards & Measures, participants from 1 health department also discussed the importance of involving everyone in QI activities, "our managers really try to incorporate the frontline staff in the quality improvement activities... so it's solidifying that knowledge by actually applying it to something that is relevant to their job." Moreover, there was consensus among participants that QI/PM were not activities that were done *in addition to* their daily work, but rather as part of it, "In everything we do, we're constantly looking at how can this be better."

Advice for other health departments regarding QI/PM

The most practical advice participants had for other small LHDs regarding QI/PM was to find a model that is easy to track and understand. One individual stated, "So, the Plan-Do-Check-Act (PDCA) is really an...easy model to follow for our staff. It lays it out so nice and easy that it doesn't feel as overwhelming and as difficult." One participant offered more philosophical advice, "Always be open to quality improvement, see every opportunity as an opportunity for improvement. There really are no failures unless you don't learn from that and take it to be able to move forward and improve." In closing, 1 participant brought the question full circle by focusing on the purposes of QI/PM:

Being able to see that because of the quality improvement efforts that we're doing, we are helping improve the experiences of our community members. We're helping improve the positive outcomes of our community members. And really, for me, those are our greatest successes. That self-empowerment and that feeling of the work that we do matters, and then being able to see that in our community and seeing just our community flourish.

Discussion

Study participants confirmed that a primary purpose of QI/PM supports their goals for pursuing reaccreditation or Pathways Recognition: to enhance internal processes and, ultimately, improve community health outcomes.[16,17] Individuals noted that their health departments had more fully integrated these processes into their daily workflow, a goal previously outlined in the literature.[20] Furthermore, 2 of the 4 health departments had purchased either a software package (Clear Impact) or platform (Asana) to help them manage their reaccreditation or Pathways Recognition activities; staff were using these same tools to support

their QI/PM efforts. The other LHDs used Excel for tracking. Despite the optional financial investment to purchase and maintain these products by 2 LHDs, participants described the value of these tools in terms of communications and project management across the health department. Our research team learned that due to limited staff and resources, small LHDs must maximize efficiencies wherever possible. Incorporating technologies was one way in which health departments accomplished this goal. There was a general sentiment among participants that they would be remiss not to adopt these technologies.

Participants spoke at length about the importance of establishing buy-in among staff members and ensuring that organizational leaders both modeled the steps of QI/PM and demonstrated their use in implementing organizational changes. One health department incorporated QI/PM training into their onboarding of new staff members. These steps are consistent with findings from Chen et al. who noted that staff were generally uncomfortable with expectations around QI/PM because they are not formally trained in these methodologies.[14] Chen et al. suggested that all staff members receive ongoing training to understand and apply QI concepts and techniques.[14]

Participants in our study described the importance of establishing a "QI mindset" and viewing their work through a "quality improvement lens." We suggest that this approach to QI/PM can only be accomplished when members of the organization have achieved high levels of competence and comfort with these concepts. In addition to training, there were other ways in which health departments incorporated QI/PM into daily practice. As discussed, managers involved frontline staff in QI activities to ensure organizational buy-in, and staff members selected QI topics based on areas of greatest interest and need. They were responsible for leading the project from beginning to end and thereby had greater ownership of and accountability for the project.

As previously stated, all 4 health departments identified a formal QI strategy (PDSA/PDCA); however, none of the participants mentioned strategies for developing or tracking change ideas (eg, run charts, Model for Improvement).[31] The research team acknowledges that QI/PM was not the primary focus of the investigation and discussions regarding QI/PM may not have been as comprehensive as necessary to gather these details. Nevertheless, it would be difficult to conduct QI activities without these fundamental principles in place. The lack of discussion about how health departments conducted QI may suggest variability in knowledge and practice. Moreover, there was no discussion about how staff members learned the basic principles of conducting QI/PM.

Previous researchers have provided evidence of the value of large local and state health department participation in quality improvement collaboratives (QICs).[2,31] QICs comprise numerous teams from 1 or more organizations to achieve a common goal by sharing ideas, information, and work. Teams undertake projects using QI methods and techniques to close a performance gap. Moreover, QICs engage participants in the full range of change implementation, from defining the problem, to designing an intervention, to implementation and evaluation, and finally to diffusion and adaptation.[32] Benefits of QICs include peer-to-peer engagement, interactions with quality improvement faculty, continuous training, technical assistance, as well as structured and action periods. Topic-specific learning collaboratives are widespread and cover issues relevant to health departments regardless of size and composition, such as the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality[33] and the perinatal quality collaboratives to improve the quality of care for mothers and babies.[34] LHDs may wish to consider more formal learning activities, such as QICs, to build capacity and skills.

Our final observation is that all 4 health departments actively gathered data from members of their communities to inform their QI/PM plans. Participants were keenly aware of the needs of their communities, and these data frequently drove their improvement efforts, including new or revised programs and services. Individuals described how staff overcame their reticence once they recognized how the processes of QI/PM connected to improved health outcomes. Therefore, it was not surprising that participants advised other small LHDs to consider the purposes of QI/PM to better serve their communities.

Implications for Policy & Practice

- Meeting PHAB Standards & Measures gives health departments a foundation to incorporate QI/PM systems and efforts on an ongoing basis.
- Small LHDs can successfully incorporate QI/PM into ongoing public health practice to better meet community needs, not just meet PHAB requirements.
- Small LHDs can improve staff QI/PM abilities and buy-in through education, staff selection and ownership of QI projects, and leadership modeling and communication of expectations.
- State health departments and other public health-related entities can provide essential QI/PM training, technology, and supports to small local and Tribal health departments.

Conclusion

We conducted a qualitative investigation with 4 small LHDs seeking PHAB reaccreditation or Pathways Recognition. We specifically focused on their experiences regarding QI/PM, which are critical components of performance improvement. Building upon the literature, participants described how they had adopted technology to integrate QI/PM processes into their daily work. Additionally, individuals discussed strategies they used to build buy-in and staff ownership of QI/PM processes, noting that individuals were more motivated once they understood how improvements would support the health and wellbeing of their community.

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