

***SYSTEMATIC RESEARCH ON
INCENTIVES
FOR PUBLIC HEALTH ACCREDITATION***

Brief Report

May 2008

BACKGROUND

The Institute of Medicine's 2003 report, *The Future of the Public's Health in the 21st Century* called for increased accountability by state and local public health agencies to perform the core public health functions and the ten essential public health services. The committee that prepared this report identified accreditation as one tool to improve the quality of service and evaluate performance of state and local public health agencies.

Public health agency accreditation is occurring in several states and a national model for accreditation of state and local public health agencies is under development. Accreditation incentives are so important that it was one of the dimensions of a national voluntary accreditation process considered by the *Exploring Accreditation (EA)* committee. Although the *Exploring Accreditation* process collected opinions about incentives, there has been no effort to systematically research which incentives are most likely to encourage voluntary participation in the national public health accreditation model by state and local public health officials.

The purpose of this research was to compile current research on accreditation incentives, identify additional potential incentives to encourage participation in the national public health accreditation model, and systematically research these various incentives to discern those that are most likely to encourage state and local health officials to volunteer their agencies to participate in the voluntary national public health accreditation model. *Exploring Accreditation* principles about incentives, i.e., incentives should be positive and not coercive or restrictive, were foundational elements of this project.

METHODS

This research occurred in three phases and used multiple or mixed data collection methods that included key informant interviews, discussion groups, and a survey (Table 1).

Table 1: Description of Accreditation Incentive Study Phases

Phase	Purpose	Method
I. Compile, synthesize, and organize current data on benefits and incentives.	To develop a comprehensive list of possible incentives of accreditation.	Literature review of accreditation incentives and discussions with <i>Exploring Accreditation</i> participants.
II. Conduct key informant interviews/discussions with potential incentives providers.	To identify additional incentives and determine the feasibility of offering various types of incentives.	Telephone calls and face-to-face meetings with federal and state agencies (Health Resources and Services Administration, Centers for Disease Control and Prevention, NC Division of Public Health) and philanthropic organizations (Robert Wood Johnson Foundation, Kansas Health Foundation).
III. Conduct research on benefits and incentives.	To determine the most compelling and relevant incentives.	a. Discussion groups held with ASTHO and NACCHO members. b. Survey of all ASTHO members and a sample of NACCHO members.

Phases I and II served as background research for the project. From these phases, the research team created a list of incentives categories (Table 2) to inform Phase III of the project.

Phase III a) Discussion Groups with ASTHO and NACCHO members. The purpose of the discussion groups was to provide feedback on the list of incentives categories, identify any additional incentives, and identify the most relevant incentives to include in the survey. ASTHO members are state health department officials or their representatives and NACCHO members are local health department officials or their representatives. Three one-hour telephone discussion group calls with 12 NACCHO participants representing nine health agencies were conducted. The research team facilitated a one-hour invited, closed session with State Health Officials or their representatives at the ASTHO 2007 meeting. There were 21 participants who were either the State Health Official or their designee at this session.

Table 2: Potential Incentives to Encourage Participation in Public Health Accreditation

Grants Application– Primarily involves incentives related to grant applications processes. May also be considered Financial or Replacement incentives. Examples for accredited health departments include:

- Preliminary applicant options
- Streamlining application process
- Accreditation status considered as part of scoring criteria.

Financial – Incentives that involve actual or potential monetary benefit to agencies that are considering or applying for accreditation or accredited agencies. May also be considered Motivational or Technical Assistance incentives.

For agencies considering accreditation, examples of funding include:

- Funds to prepare the agency to apply for accreditation
- Use of grant funds (e.g. federal block grant funds) to prepare the agency to apply for accreditation
- Funds to address potential agency deficits before applying for accreditation
- Funds for pilot accreditation projects.

For accredited agencies, funding examples include:

- Eligibility to apply for grants and contracts
- Access to funding support for quality improvements following accreditation
- Additional points or preferences on grant applications.

Marketing – Includes all incentives related to a health agency receiving recognition for undergoing accreditation.

- Awards (e.g., provision of awards to accrediting agencies)
- Classification (e.g., having accreditation with distinction ratings)
- Outcomes (e.g., promoting agendas for high quality services and improved outcomes)
- Promotion (e.g., agencies should use accreditation status for self-promotion)
- Communicates value of public health agency in community
- Communicates value of public health agency to other agencies in community.

Benefits/Motivational – Aspects of accreditation that would motivate an agency to participate through the perceived benefit of the incentives. Also could be considered “intangible” incentives. These could be incentives for individuals or groups outside the agency or incentives for individuals or groups within an agency.

External Motivational Incentives:

- Improves working relationships between agency personnel and personnel in other agencies (e.g. improved relationships between state and local personnel)
- Peer site visitors can apply what they learn from accreditation in their own health departments.

Internal Motivational Incentives:

- Accreditation process provides a team building opportunity for staff
- Process promotes staff understanding of how their job contributes to health department mission and essential services
- Accreditation can be a vehicle to demonstrate health director leadership.

Infrastructure and Quality Improvement –Includes incentives that relate accreditation to infrastructure and quality improvement as an agency prepares for accreditation and following accreditation.

- Creation or revision of policies
- Identification of areas for health department improvement
- Enhancement of recruitment and retention of high quality workforce through reputation as an enhanced working environment.

Grants Administration – Incentives that would reduce administrative burdens of grant requirements.

- Fewer reporting requirements (progress reports, audits, site visits)
- Increased flexibility to use funds and move funds
- Documentation required for accreditation matches other grant or administrative data collection requirements.

National Support - Incentives from federal agencies and foundations of visible support for accreditation as a means to improve the quality and performance of public health agencies.

- Policy statements that indicate federal agency support for accreditation
- CDC conferences that include presentations on accreditation or by accredited agencies
- Preference for CDC field assignees for accredited agencies
- Recognition from federal agencies to accredited agencies (e.g., annual listing of accredited agencies, certificates, etc)
- Foundation support for research and communications strategies that support accreditation.

Technical Assistance – Provision of technical assistance for agencies to prepare for accreditation or to address areas for quality improvement identified through the accreditation process.

- Pre-accreditation review service to evaluate readiness for accreditation
- Training, technical assistance, and consultation to prepare for accreditation
- Access to CDC field assignees to prepare for accreditation
- Receive benchmarking data and consultation on quality improvement activities
- Funding to support quality improvement for deficits identified through accreditation .

Phase III b) Survey Development and Administration. The research team administered one survey for both ASTHO and NACCHO members which was combined with a Public Health Accreditation Board survey. Questions for this research asked respondents to:

- 1) Rate how likely each incentive category was to encourage the respondent to volunteer for accreditation.
- 2) Select the two categories most likely and the one category least likely to encourage them to volunteer for accreditation.
- 3) Using open ended survey response format, describe why they chose incentives as likely or unlikely to encourage them to volunteer for accreditation.
- 4) Rate their level of agreement about their agency volunteering for accreditation.
- 5) Rate their familiarity with the national public health accreditation model and the Public Health Accreditation Board.

The survey was administered to a total of 629 individuals, 55 ASTHO and 574 NACCHO members¹. The sampling strategy for NACCHO members was provided by NACCHO and consisted of all unique email addresses for respondents to the 2005 National Profile of Local Health Departments (Profile) survey. The sampling frame was divided into 6 strata which included two subgroups of local health department governance structure (units of local government or Decentralized or units of a state agency or Centralized) and three subgroups defined by jurisdiction population: small (<50,000), medium (50,000 to 499,999) and large (> 50,000). ASTHO and NACCHO survey responses were analyzed and reported separately.

RESULTS

Response Rates

State and local health officials, or their designees, from 49 states participated in the discussion groups or surveys and approximately 50% of state and local health officials, or their representatives, who received the survey responded to it. Table 3 presents the survey response rates by overall response, ASTHO member response (state health official), and NACCHO (local health official) member response within strata.

Table 3: ASTHO and NACCHO Survey Response Rates

Category	Sample n	Response n	Response %
Overall	629	309	49.0
ASTHO Members	55*	28	51.0
NACCHO Members Total	574	281	49.0
NACCHO Decentralized	386	200	51.8
- Small	145	62	42.8
- Medium	174	96	55.2
- Large	67	42	62.7
NACCHO Centralized	188	81	43.1
- Small	88	32	36.4
- Medium	70	35	50.0
- Large	30	14	46.7

*55 states and territories received the invitation e-mail, 2 did not due to an error in survey files.

¹ South Carolina and Micronesia ASTHO representatives did not receive the survey due to an error in survey administration.

Incentives Rankings

Survey results of ASTHO and NACCHO respondent ratings of incentives are comparable; however, there are important differences (Table 4). Incentives most likely to encourage ASTHO respondents to volunteer for accreditation were: Financial Incentives for Accredited Agencies; Infrastructure and Quality Improvement; Financial Incentives for Agencies Considering Accreditation; Grants Application; and Grants Administration. ASTHO respondents indicated that these incentives were tangible, offset or cover the cost of accreditation efforts, reward efforts to undertake accreditation, and contribute to agency quality improvement efforts.

Incentive categories most likely to encourage NACCHO respondents to volunteer for accreditation were: Financial Incentives for Agencies Considering Accreditation; Financial Incentives for Accredited Agencies; Infrastructure and Quality Improvement; and Technical Assistance and Training. Many NACCHO respondents indicated that in order for them to volunteer their agencies, there would need to be financial and other supports, such as training and technical assistance, to offset the perceived costs of accreditation. Other NACCHO respondents explained that they were looking to improve the general quality of their health departments or improve infrastructure and services. It is important to note that no significant differences were found in incentives ratings among the respondents in the 6 strata in the NACCHO sampling frame.

“...my local health department Board of Directors will be much more likely to allow (and encourage) me to pursue accreditation if I can demonstrate that my and other staff time will be at least somewhat offset through a financial incentive.”

--Local health department respondent on choosing Financial Incentives for Agencies Preparing for Accreditation Incentive

Table 4: Summary Table of Incentive Categories Most and Least Likely to Encourage Participation in the national accreditation model by ASTHO and NACCHO Respondents

Incentive Category	Most Likely		Least Likely	
	ASTHO	NACCHO	ASTHO	NACCHO
Financial Incentives for Agencies Preparing for Accreditation	X	X		
Financial Incentives for Accredited Agencies	X	X		
Infrastructure and Quality Improvement	X	X		
Grants Administration	X			
Grants Application	X			
Technical Assistance		X		
National Support			X	X
Marketing and Recognition			X	X

ASTHO and NACCHO respondents both chose Marketing/Recognition and National Support as the incentive categories least likely to encourage their participation in the national accreditation model. Respondents indicated that these incentives were not as important to them or likely to

persuade their stakeholders, such as communities and elected officials. In addition, these incentives were vague and not practical for respondents. More importantly, given the perceived effort needed to undertake accreditation, these incentives were not compelling to respondents.

Knowledge and Interest in National Accreditation

The survey also examined ASTHO and NACCHO respondents' familiarity with the national voluntary public health accreditation model, Public Health Accreditation Board (PHAB), and likelihood of seeking accreditation. The majority of ASTHO respondents were familiar or very familiar with the national voluntary public health accreditation model and PHAB; and 37% of ASTHO respondents indicated that their health department would seek accreditation under the national model. NACCHO respondents were not as familiar with the national model and PHAB with just under one third indicating that they were somewhat familiar with the national model and the majority indicating that they were not at all or not very familiar with PHAB. Nevertheless, 31% of NACCHO respondents strongly agreed or agreed that they would seek accreditation.

“The data obtained from the accreditation process would help us identify areas we need to strengthen within our infrastructure. Consultation along with benchmarking data will help to advance the progress of our local and state health departments.”

--State health department respondent on choosing Infrastructure and Quality Improvement Incentive

LIMITATIONS

There are several limitations to the findings of this research. First, discussion groups for both the NACCHO conference calls and the ASTHO meeting were convenience samples of potential participants. Second, the on-line survey format limited the ability to define the incentives categories and did not allow display of all examples of incentives within specific categories. Third, for convenience and resource purposes, the on-line survey was paired with the survey about PHAB messages which introduced challenges to survey design and implementation. Finally, the wording of the survey item on familiarity with the national accreditation model asked respondents to self-interpret their own familiarity with the model which may have introduced response bias.

AREAS FOR FURTHER RESEARCH AND EXPLORATION

There were aspects of incentives identified for research that could not be addressed by this project. One of these is incentives thresholds, which means that agency's receiving an incentive is potentially dependent on other entities in the same state being accredited as well. In other words, can a state or local public health agency receive incentives in isolation of participation in accreditation by other state or local agencies in that state? A second area for additional research is the need for PHAB standards and measures that are consistent with existing federal agency grant requirements. As PHAB standards and measures are developed, this concept should be further explored. Finally, in this project, there was limited exploration of the incentives that state agencies could provide to local agencies to encourage participation in accreditation. Additional research may be needed to explore and verify incentives that state agencies can provide to local agencies.

IMPLICATIONS FOR PRACTICE

This research identified six incentives that state and local health officials indicated are likely to encourage them to volunteer their agencies for the national public health accreditation model. Three of these—Financial Incentives to Prepare for Accreditation, Financial Incentives for Accredited Agencies, and Infrastructure and Quality Improvement—were identified by both state and local health agencies. Several of the incentives designed to facilitate preparation for accreditation, such as Infrastructure and Quality Improvement and Technical Assistance, have begun to be provided by national organizations including ASTHO, NACCHO, CDC, and others. Additional initiatives to provide these incentives may be needed to encourage a sufficient number of state and local health agencies to participate in the national model. Other key incentives, such as Financial Incentives to Prepare for Accreditation, Financial Incentives for Accredited Agencies, Grants Administration, and Grants Application, have yet to be developed.

“Although there has been much discussion about national accreditation I believe that local agencies are still unclear about how the process will occur and how they will participate.”

--Local health department respondent on choosing Training and Technical Assistance Incentive

A caveat on the incentive Financial Incentives for Accredited Agencies is needed. In discussion groups and survey responses, several participants warned that this incentive could be interpreted as a disincentive for accreditation due to its potential for being punitive. Respondents could clearly see that if this incentive were in place, should they be unable to become accredited or lose accreditation status, they could lose access to funds. In discussions with CDC officials; however, the punitive nature of this incentive could be minimized by making this incentive only available to competitive grants for new programs, particularly targeted to state agencies. Other specific incentives for this category must be considered with caution.

This research identified a pervasive need for resources to state and local agencies to prepare for accreditation. Thus, additional efforts by national organizations, foundations, and federal agencies should be planned. As part of these efforts, state and local agencies may need a menu of incentives or multiple incentives may be needed at any given time. Specifically, financial incentives to prepare for accreditation, quality improvement, and technical assistance may be a particularly strong set of incentives to be offered simultaneously.

The development of existing and new incentives will need to be coordinated among national organizations, foundations, and federal agencies. Certain incentives should be provided by PHAB, such as recognition, but others may need to be provided by national organizations other than PHAB. Further, incentives will need to be pilot tested with and communicated to state and local public health agencies to ensure that the intended effect of these incentives, encouraging participation in the national voluntary accreditation model, is realized.

ACKNOWLEDGEMENTS

This study was implemented by the North Carolina Institute for Public Health (NCIPH), the service and outreach arm of the School of Public Health at the University of North Carolina at Chapel Hill. Co-principal investigators Dr. Edward Baker, NCIPH Director, and Dr. Mary Davis, Director of Evaluation Services, conducted the study with assistance from Molly Cannon, Research Associate. Dr. J. Michael Bowling, Research Associate Professor in the UNC School of Public Health Department of Health Behavior and Health Education, analyzed survey data.

As part of this study, an Advisory Group was formed comprised of the following members: Liza Corso, study Project Officer and Dennis Lennaway, PhD, MPH, Centers for Disease Control and Prevention; Marie Fallon, National Association of Local Boards of Health (NALBOH); Jim Pearsol and Lindsey Caldwell, Association of State and Territorial Health Officials (ASTHO); Grace Gorenflo and Jessica Solomon, National Association of County and City Health Officials (NACCHO); Pamela Russo, MD, MPH and Russell Brewer, DrPH, Robert Wood Johnson Foundation (RWJ); Albert Gray, PhD and Robin Wilcox, National Public Health Accreditation Board (PHAB); and Jennifer McKeever of the National Network of Public Health Institutes (NNPHI). Advisory Group members participated in quarterly conference calls and provided suggestions for study phases, important feedback on instrument protocols and drafts, and feedback on initial data analyses and draft reports.

Carolyn Leep, Director of Research for NACCHO, provided the sampling design for the NACCHO portion of the survey. Dr. Gray and Robin Wilcox of PHAB facilitated administration of the incentives survey in conjunction with their PHAB survey. Adam Burns and Jennifer Dusenberry of Porter Novelli provided assistance in facilitating communication between PHAB, NCIPH, and the survey vendor. The NCIPH research team is grateful for their assistance.

This project was supported with funding from the Centers for Disease Control and Prevention through its cooperative agreement with the National Network of Public Health Institutes. This is a brief version of the full project report. For a copy of the full report, please contact Mary Davis, DrPH, MSPH at mary_davis@unc.edu.