

North Carolina's use of the Operational Definition in their Accreditation Efforts

In late 2001, the State of North Carolina began a pilot program for accrediting local health departments (LHDs). Accreditation was first discussed on a committee composed of local health directors and the Division of Public Health (DPH) looking at standards and best practices. The committee determined that an accreditation program should begin, though there was no outside accrediting body. As such, a subcommittee on accreditation was created, and it was this subcommittee that identified parameters of the system. At the same time, there was a legislator who had recently participated in a [Public Health Leadership Institute](#) program and took a forward looking view about what needed to happen in local public health to assure a consistent level of quality across the state. With administrative support from the NC Institute for Public Health via a contract with the Division, the subcommittee began outlining a process and model, based on the core functions of public health and the [10 essential public health services](#) that would set the stage for the development of an accreditation tool. A public health task force was convened to develop a public health improvement plan for the state and a subcommittee of that group developed the first accreditation tool.

The North Carolina Division of Public Health contracted with the North Carolina Institute for Public Health to administer the accreditation program, which began with the voluntary piloting of the process in six local health departments. Today, the process is governed by a 17 member Accreditation Board appointed by the North Carolina State Division of Public Health, and is comprised of county commissioners, board of health members, local health directors, division of public health staff, division of environmental health staff, and at-large members. The LHDs selected for the Year 1 pilot project were diverse in terms of location, structure, population size, and character of the communities they serve (rural, urban, etc). The institute conducted a comprehensive evaluation of the pilot project after this first year to determine successes and areas for improvement. Feedback was gathered from those LHDs that undertook the process, the accreditation board, site reviewers, DPH Consultants and others. As revisions were made to North Carolina's tool, efforts were made to align it with [NACCHO's Operational Definition](#), which was nearing its final iteration.

Redundancies were eliminated in areas where LHDs could get marked off twice. Because both the Operational Definition and North Carolina tool are based on the 10 essential services, there was a good deal of natural alignment. North Carolina's standards are divided into three components: agency core functions and essential services, facilities and administrative services, and governance/board of health. Between the first two years of the program, the tool was reviewed to ascertain where there was alignment and where changes could be made in the North Carolina tool to make it more similar to the Operational Definition. There was language in the Operational Definition that seemed clearer and was thought to better resonate with health department staff, and so was inserted in the North Carolina tool. For example, the activity under Benchmark 4 was changed to reflect the language in the Operational Definition item 2.a.; however, a complete crosswalk to the Operational Definition still needs to be done.

“Volunteering” for Mandatory Accreditation

Recent legislation made North Carolina's accreditation program mandatory, and provided funding for LHDs to participate in the program. All 85 LHDs must be accredited by 2014. LHDs receive \$25,000 during the year they seek initial accreditation. Each year, up to 10 LHDs will be funded to go through this mandatory accreditation process, so that by 2014, all LHDs will have undertaken the process. There is no shortage of volunteers. Pilot 1 had 23 volunteers and 6 were chosen, while four were selected for Pilot II in 2005. Currently, volunteers fill the spaces available through 2008, with LHDs already signing-up to participate in 2009.

The Year 1 pilot sites represented a diverse array of LHDs. Included in this sample, was one large LHD, one average-size, one small, one multi-county district, one "other model" (i.e., not a single county or multi-county district), and one geographic wildcard. As sites were being selected for Year 2, there was concern from county commissioners about accreditation being more difficult for smaller LHDs which have fewer resources (staff and money), so efforts were made to ensure that small, rural communities were included in the Year 2 pilot sites.

To address that concern, Pilot II looked at whether or not departments could become accredited when services were provided to their constituencies by a neighboring county. Related to that were concerns over whether accreditation would lead to forced districting of LHDs. The final report of the Public Health Task Force 2004 clarified that accreditation was not an attempt to force districting, but rather to enhance or change practices as necessary to meet the standards for accreditation. A health department that could not meet an accreditation standard on its own could contract with a neighboring county to provide that service to its citizens and show that contract and service data provided by the neighboring county as documentation for meeting the standard.

Challenges and Lessons Learned

One concern in North Carolina relates to making sure that the local health department is not penalized when the state division of public health has not done its part. If the state does not monitor a specific LHD program and has not provided documentation that the local agency is in compliance with all program requirements, the local agency should not be penalized. If this is raised as an issue for the LHD during accreditation, the state may try to conduct monitoring while the LHD is in the midst of their self assessment, causing problems for the local agency trying to complete the monitoring requirements, complete the self-assessment and keep agency services to citizens going at the same time. Currently, the DPH is working to ensure all programs "get ahead of the curve" and focus now on the 2007 accreditation sites.

In hindsight, the state feels that having county commissioners on board earlier would have been useful so that they were better informed and could function as partners in seeking legislation and funding for the accreditation process. To bring them on board, several meetings were held with their leadership, they were a part of selecting the agencies for Pilot II and four seats on the Accreditation Board were set aside for county commissioners, which helped to allay any tension and strengthen their involvement. Boards of Health members

were involved in the process from its inception, are a part of all site visit teams and also have four seats on the Accreditation Board.

Efforts to Accredite the North Carolina Division of Public Health

From the beginning, local health departments were clear that they also expected the Division of Public Health to go through a similar process. In 2004, a public health task force reiterated the expectation for the state to undertake an assessment. No national governing body oversees a state accreditation process. A committee composed of representatives from the local health departments, DPH, the NC Institute for Public Health and the Division of Environmental Health, has worked to develop a modified version of the State Instrument of the National Public Health Performance Standards, which focuses only on the state health department rather than the entire public health system. The state accreditation program has not begun, though the tool is currently being finalized. Mimicking the local program, the Division will have three months to complete their self-assessment and put together the documentation for a site visit approximately 6-8 weeks after completion of the self-assessment. Because the state health director feels very strongly that state level accreditation take place, a new state position has been added to oversee this process for the division.

Lessons Learned

- Including all key partners early on in the process allows for more support throughout the process and less work in soliciting support on the backend.
- It is important to maintain energy and momentum throughout the process. Having a committed leader with a vested interest in staying on track is helpful.