The Relationship Between Accreditation and Local Public Health Agencies' Foundational Public Health Services Capacity in Missouri

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Summary Findings

Accreditation is rare: Only 18.9% of LPHAs have achieved some form of accreditation

Full assurance of the Foundational Public Health Services (FPHS) model is needed: 44.1% of Local Public Health Agencies (LPHAs) assure their community access to the minimum set of foundational capabilities and public health areas of expertise defined in Missouri's FPHS model; 31.5% are not yet able to assure the full model.

Accreditation predicts capacity…: Accredited LPHAs are 2.7 times more likely to fully assure the FPHS model than unaccredited agencies. 76.2% of accredited LPHAs fully assure the FPHS model compared to 36% of LPHAs without accreditation.

…but, accreditation does not guarantee capacity: Roughly 70-80% of LPHAs are not considering pursuing accreditation, yet among non-accredited LPHAs, the same percentage fully assure the FPHS model (36%) as those who do not (36%).

Urbanization predicts accreditation: 66.6% of accredited LPHAs are in urban and semi-urban areas, 61.8% of non-accredited LPHAs are in rural and densely-settled rural areas.

FPHS assurance is not dependent upon accreditation agency: 73.3% full assurance with MICH accreditation; 85.7% full assurance with PHAB accreditation

Accreditation can be a mechanism for FPHS assurance: If pursuit of accreditation begins with establishing quality-improvement processes and developing the LPHA workforce, benefits will accrue even before the LPHA achieves accreditation standards.

Further accreditation will require resources: LPHAs need both funding and staffing resources to assure the FPHS model, along with support for developing an agency strategic plan, community health improvement plan, workforce development plan, and a community health assessment, in order to achieve accreditation standards.

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The #HealthierMO initiative surveyed public health professional across the state for a comprehensive report on Missouri's Foundational Public Health Services (FPHS) model. As part of that initial survey, LPHAs were asked about their progress toward accreditation through Missouri Institute for Community Health (MICH) and/or their progress toward accreditation through national Public Health Accreditation Board (PHAB). Given the known overlap between accreditation standards of PHAB or MICH and the National Foundational Public Health Services model, it is reasonable to assume that achieving accreditation would predict ability to provide the full FPHS model. To examine this hypothesis, we revisited the dataset to discover the relationship between accreditation and FPHS capacity in Missouri.

Rates of Accreditation

Any consideration toward transformation of public health in Missouri through promotion of accreditation should begin with the understanding that accreditation is relatively rare in Missouri. Only 18.9% of LPHAs have achieved some form of accreditation from either PHAB (6.3%) or MICH (13.4%). Only one LPHA has accreditation from both. LPHAs are twice as likely to be accredited by MICH (n = 15) as by PHAB (n = 7). Table 1 shows that 13.4% of LPHAs are currently accredited by MICH, 7.2% are accredited by or seeking accreditation from PHAB. A relatively larger number of LPHAs are "on the fence," considering seeking accreditation within the next 2 years from either MICH (17%) or PHAB (11.6%). However, the vast majority are not considering applying for accreditation from either MICH or PHAB (69.6% and 80.4%, respectively), citing lack of time and resources as primary barriers. Because the percentages of accredited to non- accredited, LPHAs are so unbalanced (19% vs. 81%),

interpretations about the relationship between accreditation and FPHS capacity in Missouri must be made considering each group. Conclusions based upon either group alone are more likely to be misleading than if an analogous pattern also exists in the other group.

Table 1
Self-reported progress toward accreditation by MICH and/or PHAB

	MICH		PHAB	
	N	%	N	%
We are currently accredited and not due for reaccreditation for 2 years	15	13.4%	4	3.6%
We are currently accredited and not due for reaccreditation for 1 year	0		3	2.7%
We have applied for accreditation and are currently completing documentation	0		1	0.9%
We are NOT currently accredited, but are considering applying within the next year	5	4.5%	2	1.8%
We are NOT currently accredited, but are considering applying within the next 2 years	14	12.5%	11	9.8%
We are NOT currently accredited, and we are not considering applying for accreditation	78	69.6%	90	80.4%
Missing			1	0.9
Total	112	100%	112	100%

Assurance of the FPHS Model

Assurance of the full FPHS model is relatively more common than LPHA accreditation: 44.1% of LPHAs assure the full model (both Capabilities and Areas of Expertise), 24.3% assure the partial model (typically Areas but not Capabilities), and roughly a third (31.5%) are not providing either Capabilities or Areas to the degree needed in their communities. Among the roughly 20% of accredited LPHAs, the relationship between accreditation and FPHS capacity is robust. Accredited LPHAs are 2.7 times more likely to fully provide the FPHS model than unaccredited agencies (X^2 (1, N= 111) = 11.46, p < .001). Indeed, among LPHAs who maintain some form of accreditation (either PHAB, MICH, or both), 76.2% fully assure the FPHS model

compared to 36% of LPHAs without accreditation who assure the full model.

Although accreditation predicts the ability to fully assure the FPHS model, it does not guarantee the ability. Among non-accredited LPHAs, the same percentage fully provide the FPHS model (36%) as those who do not provide at the minimal level (36%). Neither does the source of the accreditation matter for outcomes (73.3% full assurance with MICH accreditation vs. 85.7% full assurance with PHAB accreditation). Table 2 specifies the relationship between accreditation and level of FPHS assurance. Although full assurance of the FPHS model is related to accreditation among accredited LPHAs, the relationship does not hold as strongly for non-accredited LPHAs. Many non-accredited LPHAs are able to provide partially and fully without accreditation, indicating that accreditation may be a tool or an incentive, but not a guarantee of public health service provision.

Table 2

Assurance of FPHS related to level of Accreditation

	Level of Assurance of FPHS Model			
	Incomplete	Partial	Full Model	Total
Accredited	3	2	16	21
	14.3%	9.5%	76.2%	
Non-accredited	32	25	32	89
	36%	28%	36%	
MICH accredited	2	2	11	15
PHAB accredited	1	0	6	7
Total	35	27	48	110
% Accredited	31.8%	24.5%	43.6%	

Note. One LPHA was accredited by both MICH and PHAB and also provided the full model

For greater clarity of the relationship between accreditation and capacity, LPHAs can be grouped as providing the full model (43.8%) contrasted to those providing less than the full model (56.3%), or alternatively as those providing neither capabilities nor areas (Incomplete; 31.3%) contrasted to those who can at least assure part (Partial) or perhaps all of the model

(68.8%). Table 3 further explores these relationships.

Although being accredited robustly predicts ability to fully provide FPHS, *not* being accredited is not predictive of *not* providing the model at needed levels (i.e., providing neither Capability nor Areas, called "Incomplete" in the Table 2); 35.6% of non-accredited LPHAs are not providing the FPHS model, meaning that two-thirds (64.4%) of LPHAs have the capacity to provide part or all of the model ("partial" in Table 2) without being accredited. LPHAs who are not accredited are 2.48 times less likely to have capacity to assure the FPHS model partially or fully than LPHAs who are accredited; however, the difference in distribution is not statistically significant (X^2 (1, N= 111) = 3.57, p = .06). This pattern held no matter whether the LPHA was accredited by PHAB or MICH.

Table 3
Progress toward accreditation by MICH and/or PHAB

	Assurance of FPHS model				
	Incomplete	Partial or Full	Partial or Incomplete	Fully Providing	Total
Accredited	3	18	5	16	21
	14.3%	85.7%	23.8%	76.2%	100%
Non-accredited	32	58	58	32	90
	35.6%	64.4%	64.4%	35.6%	100%
Total	35	76	63	48	111
% Accredited	31.5%	68.5%	56.8%	43.2%	100%

Note. One LPHA was accredited by both MICH and PHAB and also provided the full model

Accreditation and Urbanization

The links between accreditation and assurance of the FPHS model were further explored in their relationship to the level of urbanization for the LPHA community. Level of urbanization predicted accreditation: 66.6% of accredited LPHAs are in urban and semi-urban areas, 61.8% of non-accredited LPHAs are in rural and densely-settled rural areas. The preponderance of

accredited LPHAs assuring the full FPHS model (68.8%) were in urban (37.5%) and semi-urban (31.3%) areas; 62.5% of non-accredited LPHA who assured the fully model were in rural and densely-settled rural areas.

Table 4
FPHS model assurance as a function of accreditation and level of urbanization

FPHS Model Assurance		Level of Urbanization				
		Rural	Densely-settled rural	Semi-urban	Urban	Total
Full Model	Accredited	3	2	5	6	16
		18.8%	12.5%	31.3%	37.5%	
	Non-accredited	10	10	9	3	32
		31.3%	31.3%	28.1%	9.4%	
Partial Model	Accredited	1	1	0	0	2
		50%	50%			
	Non-accredited	6	10	9	0	25
		24%	40%	36%		
Not assuring	Accredited	0	0	2	1	3
		0.0%	0.0%	66.7%	33.3%	
	Non-accredited	6	13	10	3	32
		18.8%	40.6%	31.3%	9.4%	
Total	Accredited	4	3	7	7	21
		19.0%	14.3%	33.3%	33.3%	
	Non-accredited	22	33	28	6	89
		24.7%	37.1%	31.5%	6.7%	
Marginal Total		26	36	35	13	110
		23.6%	32.7%	31.8%	11.8%	

Note. Partial model assurance indicates assuring either capacities or areas, but not both

Barriers to Accreditation

All LPHAs, both accredited and not, were asked about barriers to accreditation. Overall, the most commonly identified barrier to seeking accreditation offered was that accreditation is cost prohibitive (71.6%) and accreditation is time prohibitive (68.8%). An examination of patterns between accredited and non-accredited LPHAs showed that 61.5% of accredited LPHAs said they had no significant barriers to accreditation and only 11.7% and 12% cited cost and time

respectively as a barrier to future accreditation. Table 5 displays the barriers to accreditation.

A closer examination of the ~80% of non-accredited LPHAs, however, revealed that the generalized concerns about time and cost were actually lower barriers than concerns about developing an agency strategic plan (95.0%) and developing a community health improvement plan (90.9%), indicating that direct support and training will be crucial to increasing levels of accreditation in Missouri's public health system. Recommendations for using required accreditation as a mechanism for transforming public health in Missouri, therefore, should specifically address barriers to accreditation identified by non-accredited LPHAs of developing an agency strategic plan (95.0%), community health improvement plan (90.9%), workforce development plan (87.0%), and conducting a community health assessment (82.4%), all of which would require additional funding, staff-hours, and training. Additional funding could help LPHAs with costs, but additional staff may be necessary to give LPHAs sufficient time to work on accreditation.

Table 5
What barriers do you see to becoming accredited in the next 3 years?

	Accredited		
	Yes	No	Total
Accreditation is cost prohibitive	9	68	77
	11.7%	88.3%	
Accreditation is time prohibitive	9	66	75
	12.0%	88.0%	
Developing a Workforce Development Plan	3	20	23
	13.0%	87.0%	
Developing a Community Health Improvement Plan	2	20	22
	9.1%	90.9%	
Developing an agency Strategic Plan	1	19	20
	5.0%	95.0%	
Conducting a Community Health Assessment	3	14	17
	17.6%	82.4%	
Other barrier (unspecified)	4	10	14
	28.6%	71.4%	
No significant barriers	8	5	13
	61.5%	38.5%	

What is Needed for Accreditation and FPHS Provision?

The second most common need LPHAs identified as a requirement for assuring FPHS services effectively (behind additional funding) was the need for additional training for their current staff. Addressing the "time-prohibitive" barrier to accreditation is fundamentally a question of staffing and training, given the need for qualified staff to assure the accreditation standards and to conduct the various community assessments identified above.

LPHAs were asked about how lack of training affected their ability to provide the 10 Essential Public Health Services (EPHS). Although the top identified need was for research or to evaluate program effectiveness – which may be addressed at a regional or statewide level, rather than local – the second highest need for 51.9% of non-accredited LPHAs was to *evaluate*

effectiveness, accessibility and quality of personal and population-based health services. This need echoes the need for support and training to conduct community assessments, as does the difficulty to *develop policies and plans that support individual and community health efforts* (ranked #4). Nearly a quarter of LPHAs (23.4%) identified *diagnose and investigate health problems and health hazards in the community* as difficult to do because of a lack of trained staff. Specifics about the effect of a lack of trained workforce on assuring essential public health services are contained in Table 6, many of which quantify the level of need for staff training among non-accredited LPHAs.

Table 6

Which 10 Essential Public Health Services are difficult to do because of lack of trained workforce?

	Accredited		Total
	Yes	No	
Research for new insights and innovative solutions to health problems	9	54	63
	69.2%	70.1%	58.2%
Evaluate effectiveness, accessibility and quality of personal and population-based health services	8	40	48
	61.5%	51.9%	44.5%
Enforce laws and regulations that protect health and ensure safety	3	39	42
	23.1%	50.6%	39.1%
Develop policies and plans that support individual and community health efforts	3	35	38
	23.1%	45.5%	35.5%
Assure a competent public and personal health care workforce	2	18	20
	15.4%	23.4%	19.1%
Diagnose and investigate health problems and health hazards in the community	1	18	19
	7.7%	23.4%	17.3%
Mobilize community partnerships and actions to identify and solve health problems	2	16	18
	15.4%	20.8%	16.4%
Monitor health status to identify and solve community health problems	1	13	14
	7.7%	16.9%	12.7%
Inform, educate, and empower people about health issues	2	9	11
	15.4%	11.7%	10.0%
Link people to needed personal health services and assure the provision of health care	2	8	10
	15.4%	10.4%	9.1%
Total	13	77	90

Note. Percentages and totals are based on number of respondents.

Conclusions and Recommendations

Overall, the analysis provides partial support for a link between accreditation and FPHS capacity; however, the link is correlational, rather than causal. A strong relationship exists between accreditation and fully providing the FPHS model among accredited LPHAs. The limited number of LPHAs well-resourced enough to have already achieved accreditation from one or both accrediting agencies (MICH or PHAB), are 2.7 times more likely to provide fully the FPHS model. On the other hand, the relationship between accreditation and fully providing the FPHS model is much weaker among non-accredited LPHAs. This finding may be because – given the known overlap between accreditation standards and FPHS model specifications – in meeting accreditation standards, an LPHA is highly likely to fully meet the FPHS minimums, by definition.

Whereas accreditation *does* predict ability to provide the full model, non-accreditation does not predict non-capacity. LPHAs without accreditation provide the FPHS model at all levels (full, partial, incomplete). The analysis does not support an assertion that simply requiring all Missouri LPHAs to achieve accreditation would improve FPHS provision across the state. In fact, considering the identified barriers to accreditation among roughly 80% of LPHAs, un-resourced requirements for accreditation are likely to be counterproductive. Given that the best predictor of being able to provide the full FPHA model (from the original analysis) was level of per capita funding, next steps toward transformation should being with an assessment of the level of funding and current LPHA needs.

Accreditation is time- and money-intensive. Many LPHAs say that they currently lack the essential capacity to complete the accreditation process. Requiring accreditation without a thoughtful consideration of LPHA needs for funding and staffing (in the form of FTEs) would

reasonably be expected to degrade performance, as LPHAs might be forced to reallocate already scarce resources away from other services.

Accreditation is a sign of LPHAs being well-resourced enough to have sufficient time, money, and training to pursue accreditation. The true value of pursuing accreditation accrues from establishing quality-improvement processes and developing the LPHA workforce in service of achieving recognized standards in public health assurance. A reasonable first step toward meeting this goal would be to equip every LPHA with the funding and staffing resources needed to bridge existing funding gaps and assure the minimum standards defined in the FPHS model so that every Missouri community has equitable access to foundational public health services. Then, with sustainable funding and adequate staffing, LPHAs could build on that foundation to pursue accreditation standards.