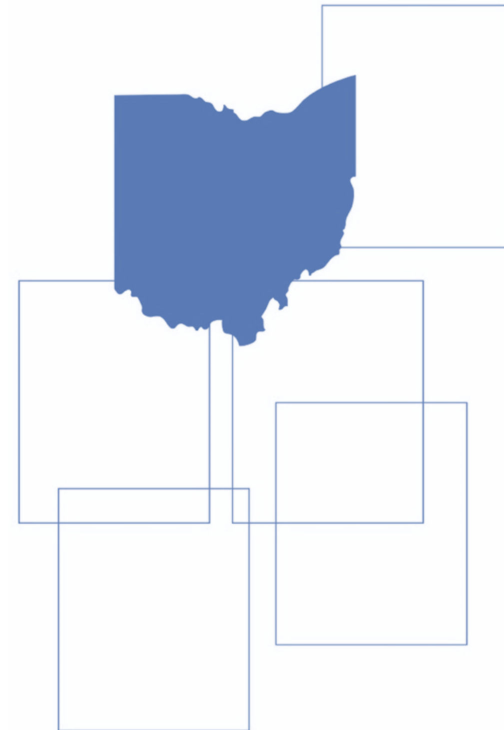
OHIO LOCAL PUBLIC HEALTH ACCREDITATION SUPPORT PROJECT: ACCREDITATION READINESS REASSESSMENT REPORT

Ohio Comprehensive Report

Revised December 2018



THE OHIO STATE UNIVERSITY

Center for Public Health Practice

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Introduction

The Center for Public Health Practice (CPHP) and the Ohio Department of Health (ODH) are supporting local public health accreditation efforts through the Ohio Local Public Health Accreditation Support Project. This three-year initiative has two purposes: 1) to answer critical questions related to local health department (LHD) accreditation and service provision, and 2) to assist LHDs in achieving accreditation.

As part of this project, in October 2016, a multi-component assessment was conducted to provide a profile of LHD accreditation readiness and financial information in Ohio. In February of 2018, a follow up survey was conducted allowing for a comparative analysis. A report published in July 2018 presents the information from the follow up assessment, with comparisons to the October 2016 assessment.

Note: This report has been from revised from the previous July 2018 version, correcting misclassifications for four LHDs in the county type groupings. For a list of the counties changing classification in the revision, see Appendix B.

Report Description

Divided into three sections, this report highlights several areas of change in accreditation stage and readiness. To make appropriate comparisons, this report presents data only from those 106 LHDs that responded to both 2016 and 2018 surveys out of a possible 114. The first section, *Survey Respondent Description*, is a general overview of the characteristics of LHDs responding to both surveys. The second section, *Accreditation Readiness*, places each health department within the accreditation readiness continuum based upon their survey responses. The third section, *Revenue and Expenditures* includes aggregated data related to spending, revenue and staffing for responding LHDs. Comparisons within all sections are presented based on LHD population size served and county type. Additional comparisons are shown using combined categories including both population size served and county type (see Appendix B). Descriptive text is provided to highlight findings illustrated in various tables and figures. Considerations to be noted when using this report include, data do not represent all LHDs in Ohio and data are self-reported. Finally, while this report includes data related to accreditation readiness, CPHP does not represent or speak on behalf of the Public Health Accreditation Board (PHAB).

1. Survey Respondent Description

Table 1: Description of Assessment Respondents, 2016 and 2018.

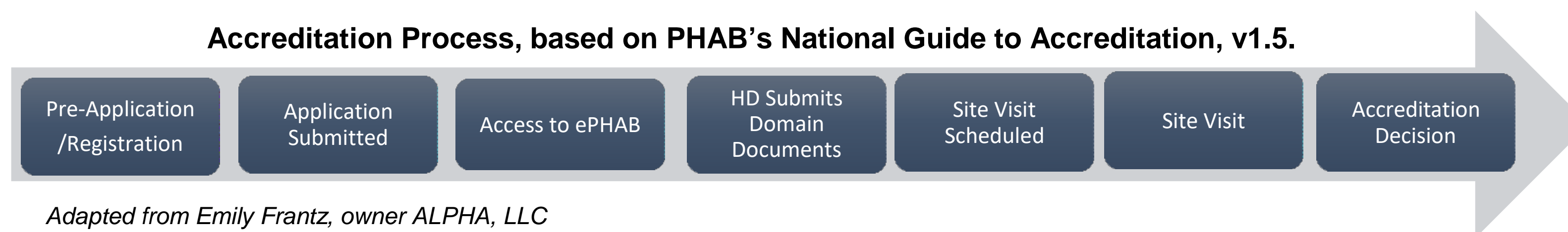
Jurisdiction Type	**Number LHDs Responding both in 2016 and 2018**	
City	23	
County/Combined	83	
Population Size Served		
Very Small (<25,000)	20	
Small (25,000-49,999)	37	
Medium (50,000-99,000)	23	
Large (100,000-499,999)	22	
Very Large (≥500,000)	4	
County Type		
Appalachian	39	
Rural, Non-Appalachian	32	
Suburban	19	
Urban	16	
	2016 Assessment	**2018 Assessment**
Accreditation Status	**Number LHDs**	
Accredited	13	17
Not Accredited	93	89
Revenue/Expenditures/Employees*	**Mean (Standard Deviation)**	
Per Capita Revenue (with Carryover)	$60 (51)	$66 (47)
Per Capita Expenditures	$41 (34)	$45 (35)
Total Full-time Equivalents	44 (72)	44 (74)
Full-time Equivalents per 10,000 People	5.5 (5.0)	5.6 (4.5)
Revenue Quartile*	**Revenue ($)**	
Minimum	$177,985	$203,567
Quartile 1	$1,193,583	$1,403,908
Median	$2,660,383	$2,936,563
Quartile 3	$5,811,750	$5,792,209
Maximum	$51,938,836	$58,327,964

** Revenue and Expenditure data reported in the 2016 and 2018 assessment is from 2015 and 2017, respectively.*
N=106

2. Accreditation Readiness

The re-assessment asked LHDs for their current stage of accreditation, with the responses compared to 2016. Response options were the same for both assessments and included: Not Yet Started, But Plan To; Pre-Application/Registration; Application Submitted; Access to e-PHAB; HD Submits Domain Documents; Site Visit Scheduled; Site Visit Completed; Accreditation Decision (either Accredited, Not Accreditation or Action Plan); and Do Not Intend to Apply, reflected in the Accreditation Process figure below.

Accreditation Process, based on PHAB's National Guide to Accreditation, v1.5.

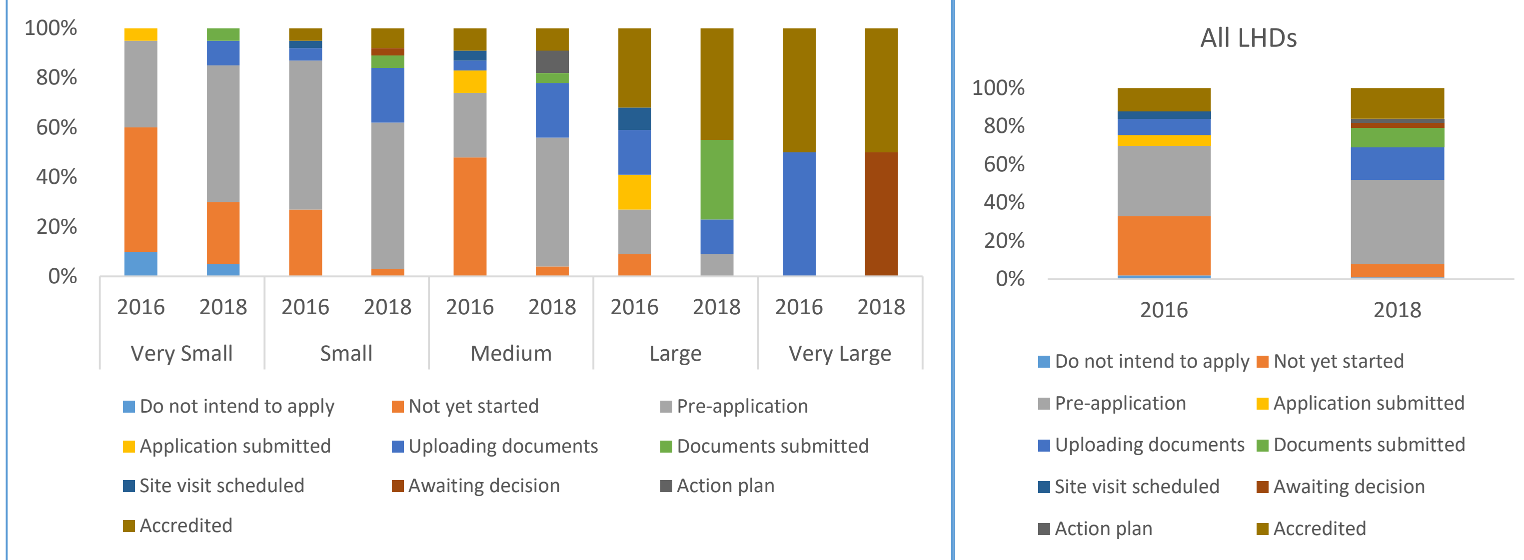


Adapted from Emily Frantz, owner ALPHA, LLC

Figure 1, on the following page, reports the accreditation stage by population size served, Figure 2 reports the stage by county type only, and Figure 3 reports on stage by county type, size and year. Tables 2 and 3 report the percent of readiness by population size served and county type. Accreditation readiness was measured via responses to select questions from the PHAB accreditation readiness checklist (e.g. Health Commissioner Support, LHD Budgeted for Cost).

This section also contains data from the Ohio Profile and Performance Database (OPPD) related to PHAB Standard completion rates, as entered by individual LHDs in March of 2018. Data includes the lowest standard completion rates (Table 4) and average percent completion of select standards (areas needing most improvement) by county type and size (Table 5). Full Domain and Standards descriptions can be referenced at [http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/.](http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/)

Figure 1: Accreditation Stage by Population Size Served and All LHDs, 2016 and 2018



n =106

Figure 2: Accreditation Stage by County Type, 2016 and 2018

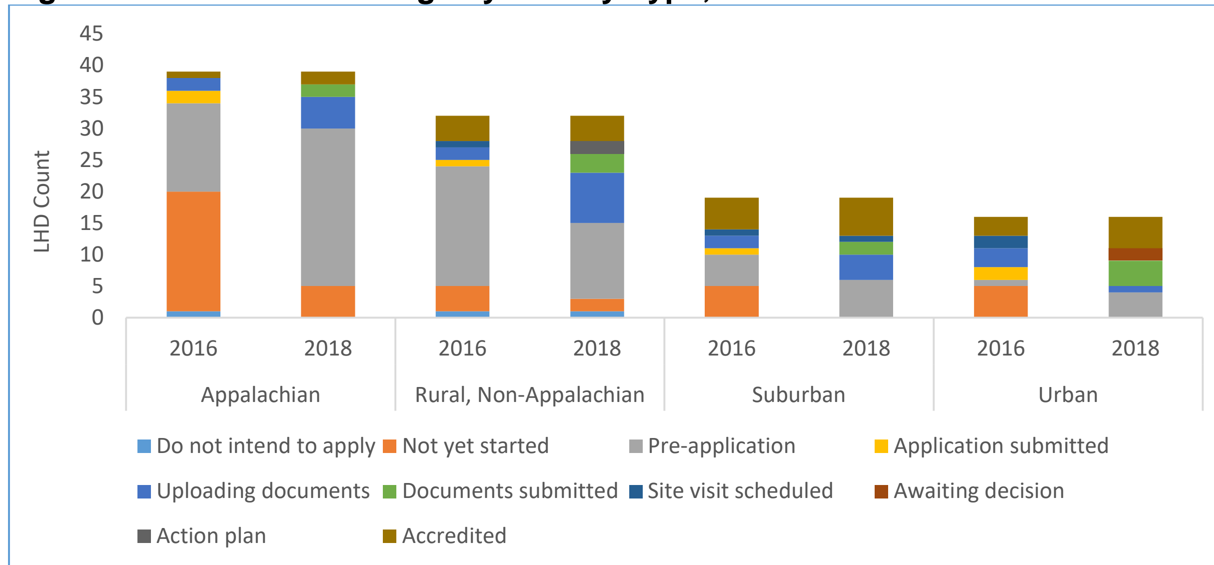
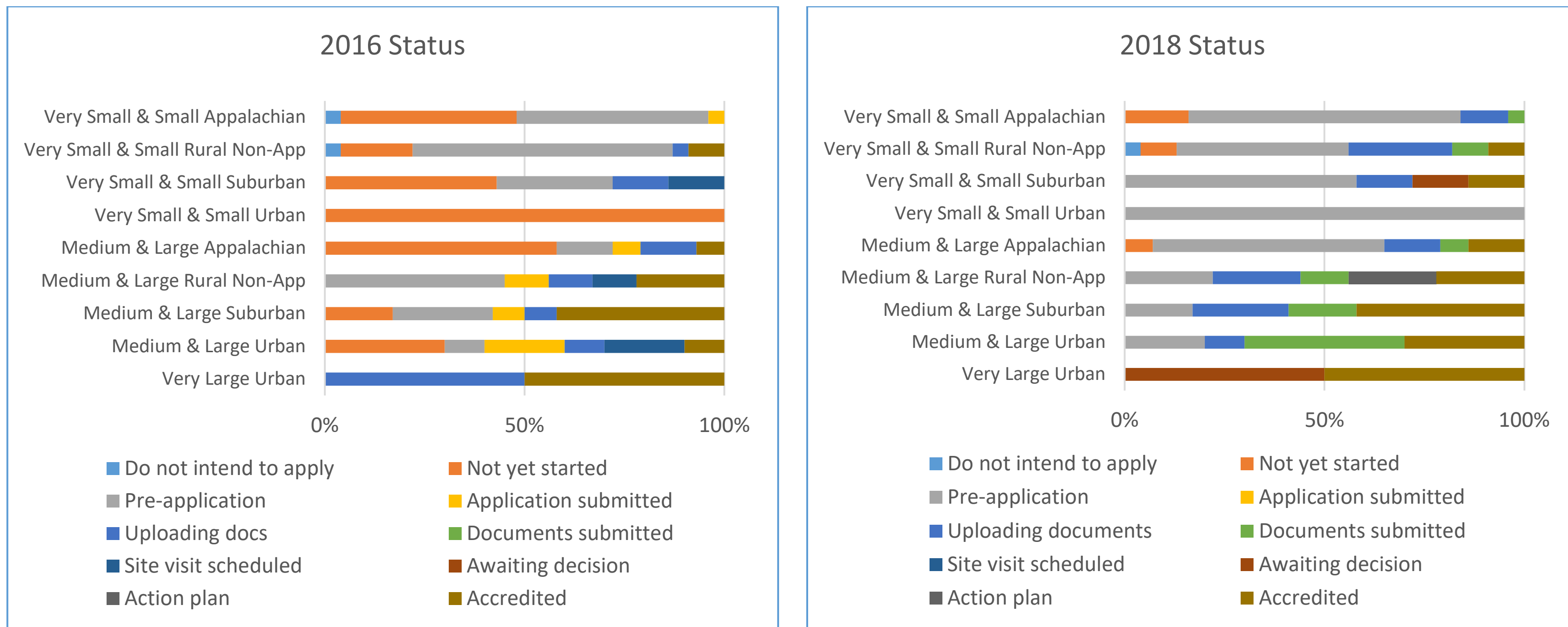


Figure 3: Percentage of LHDs in Accreditation Stage by County Type, Size and Year, 2016 and 2018



Figures 1-3 Key Information

- Progress has been made by LHDs in all categories.
- 26 out of the 33 LHDs that reported a stage of "*Not Yet Started*" in 2016 have progressed in 2018.
- Smaller Rural and Appalachian districts remain in earlier stages compared to larger more Urban districts; however, they have also shown progress along the accreditation continuum.
- Not only had more LHDs started the accreditation process in 2018 compared to 2016, but more LHDs reported submitting documents in 2018 compared to 2016, indicating movement along the accreditation process continuum.

Table 2: Percent Responding Yes to Readiness Questions by Population Size Served and all LHDs, 2016 and 2018

	Very Small		Small		Medium		Large		Total	
Readiness Question	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**
Health Commissioner Support	84%	94%	100%	100%	88%	100%	100%	100%	93%	99%
Board of Health Support	79%	94%	97%	100%	82%	92%	83%	100%	85%	97%
Board Informed of Key Elements	95%	94%	100%	96%	100%	92%	100%	100%	99%	96%
LHD Budgeted for Costs	26%	65%	72%	92%	53%	92%	83%	100%	59%	87%
Accreditation Coordinator Appointed	63%	76%	84%	96%	82%	100%	100%	100%	82%	93%
Internal Accreditation Team Designated	63%	82%	91%	96%	82%	92%	67%	100%	76%	93%
Internal Communications Plan	47%	71%	53%	71%	65%	92%	67%	50%	58%	71%
Process for ID/Review of Documents	37%	59%	59%	88%	65%	54%	67%	100%	57%	75%
Electronic Filing System Established	37%	53%	75%	92%	71%	62%	83%	50%	67%	64%
Self-Assessment Conducted	26%	53%	69%	79%	71%	85%	83%	100%	62%	79%
#LHDs Responding to Questions	19	17	32	24	17	13	6	2	74	56

**Only LHDs that had not applied for accreditation were required to answer all questions. For example, among very small LHDs in 2016 there were 19 that were required to answer all questions (meaning they had not yet applied); however, in 2018 there were 17 that were required to answer all questions, with the other two having since applied for accreditation.*

Table 3: Percent Responding Yes to Readiness Questions by County Type and all LHDs, 2016 and 2018

	Appalachian		Rural Non-Appalachian		Suburban		Urban		Total	
Readiness Question	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**	**2016**	**2018**
Health Commissioner Support	94%	100%	96%	94%	80%	100%	100%	100%	93%	99%
Board of Health Support	88%	97%	92%	94%	70%	100%	100%	100%	88%	98%
Board Informed of Key Elements	100%	97%	100%	100%	90%	83%	100%	75%	98%	89%
LHD Budgeted for Costs	56%	90%	54%	81%	80%	83%	33%	50%	56%	76%
Accreditation Coordinator Appointed	74%	97%	79%	75%	90%	100%	100%	100%	86%	93%
Internal Accreditation Team Designated	79%	93%	88%	81%	70%	100%	67%	100%	76%	94%
Internal Communications Plan	62%	73%	50%	81%	50%	83%	50%	50%	53%	72%
Process for ID/Review of Documents	41%	70%	71%	75%	70%	83%	50%	50%	58%	70%
Electronic Filing System Established	56%	63%	79%	81%	80%	100%	33%	50%	62%	74%
Self-Assessment Conducted	47%	73%	71%	75%	80%	100%	50%	25%	62%	68%
#LHDs Responding to Questions	34	30	24	16	10	6	6	4	74	56

**Only LHDs that had not applied for accreditation were required to answer all questions. For example, among very small LHDs in 2016 there were 19 that were required to answer all questions (meaning they had not yet applied); however, in 2018 there were 17 that were required to answer all questions, with the other two having since applied for accreditation*

Tables 2 and 3 Key Information

- There is improvement in completion rates for nearly all of the readiness questions.
- Nearly all LHDs responding in 2018 reported having an accreditation coordinator and an internal team designated.
- In 2018 the least completed readiness step when categorized by size was having an electronic filing system established.
- In 2018 the least completed readiness step when categorized by county type was having conducted a self-assessment.

Table 4: Change in Average Percent Completion of Standards with Lowest Completion Rates in 2016 (n=106)

Standard		Avg. Percent Complete, 2016	Avg. Percent Complete, 2018
Standard 9.2	Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions	47%	66%
Standard 9.1	Use a performance management system to improve organizational practice, processes, programs, and interventions	50%	70%
Standard 5.2	Conduct a comprehensive planning process resulting in a tribal/state/community health improvement plan	54%	80%
Standard 5.3	Develop and implement a health department organizational strategic plan	61%	81%
Standard 10.2	Promote understanding and use of research results, evaluations, and evidence-based practices with appropriate audiences	63%	78%

Table 5: Average Percent Completion of Select Standards by County Type and Size, 2018 (n=106)

Source OPPD	Very Small & Small Appalachian (n=25)	Very Small & Small Rural Non-Appalachian (n=23)	Very Small & Small Suburban (n=7)	Very Small and Small Urban (n=2)	Medium & Large Appalachian (n=14)	Medium & Large Rural Non-Appalachian (n=9)	Medium & Large Suburban (n=12)	Medium & Large Urban (n=10)	Very Large Urban (n=4)
Standard 5.2	69%	88%	83%	100%	83%	70%	88%	72%	100%
Standard 5.3	68%	77%	81%	84%	91%	74%	97%	90%	100%
Standard 8.2	80%	89%	94%	100%	85%	79%	97%	97%	100%
Standard 9.1	49%	70%	63%	100%	75%	71%	91%	79%	100%
Standard 9.2	40%	62%	57%	100%	79%	78%	86%	73%	100%

Color indicates completion rates:

0%-50%
50%–75%
76%-100%

Tables 4 and 5 Key Information
- The greatest change over time is seen with Standard 5.2, creation of a Community Health Improvement Plan.
- Table 5 shows that Standards 9.2 and 9.1, related to quality improvement and performance management, had the lowest completion rates in most LHD categories, with Very Small and Small Appalachian LHDs reporting the lowest completion rates.

3. Revenue and Expenditures

This section reviews information from annual financial report (AFR) data from the 106 LHDs responding to both assessments and submitted to ODH in March of 2016 (containing 2015 financial data) and April of 2018 (containing 2017 financial data). Data are presented for LHDs by population size served, county type, as well as by using the designated groupings of combined county type and population sized served as noted in Appendix B. Per capita revenue and expenditures were also calculated as total revenue and expenditures divided by population size served.

Figure 4. Median Per Capita LHD Revenue and Expenditures by Population Size Served, 2015 and 2017

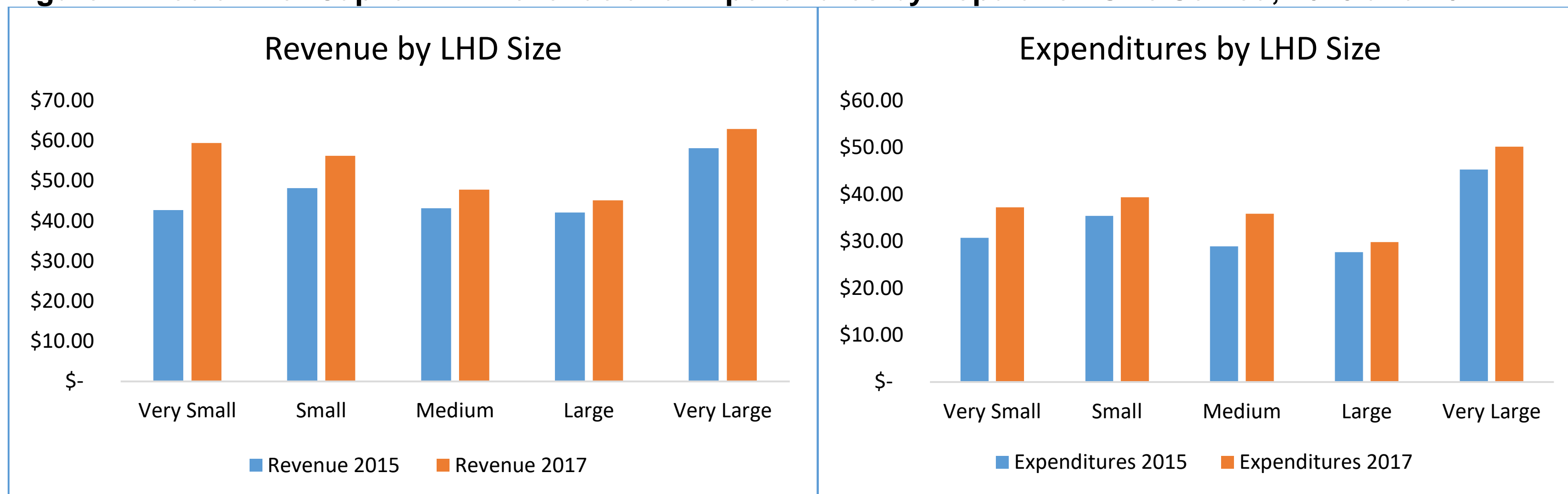
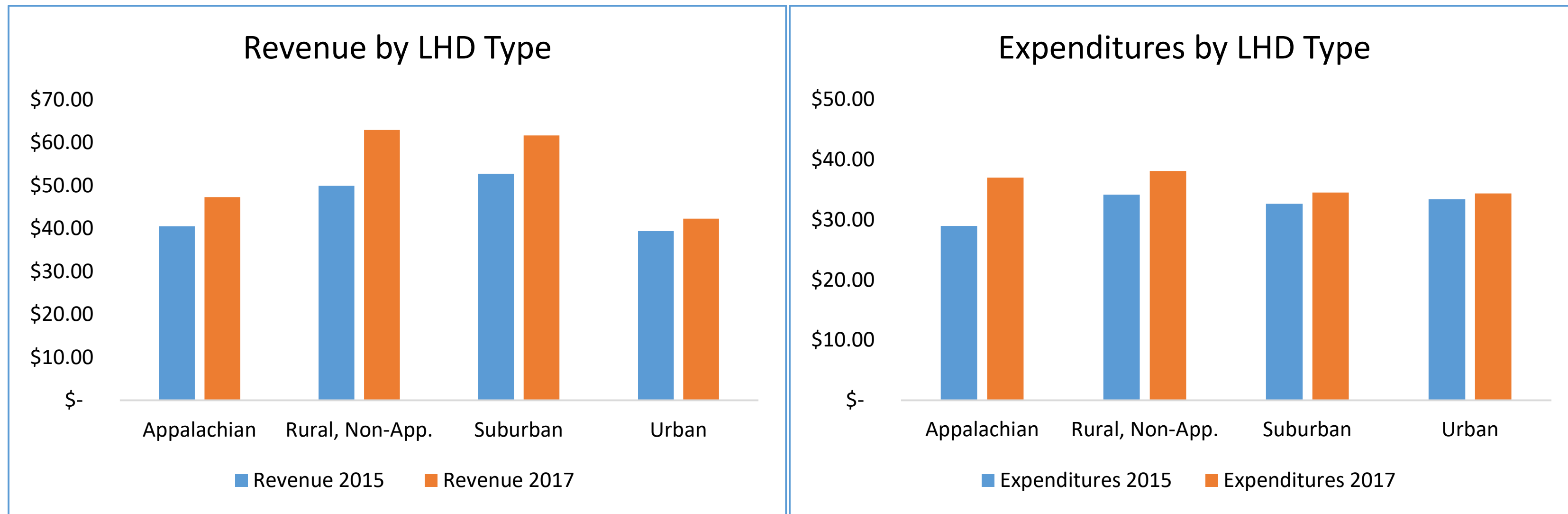


Figure 5. Median Per Capita LHD Revenue and Expenditures by County Type, 2015 and 2017



Figures 4 and 5 Key Information

- Both per capita revenue and expenditures increased in 2017 in all categories of population size served and county type.
- Very Small LHDs reported the largest increase in per capita revenue (nearly $17 per person) of all population size served categories.
- Rural, Non-Appalachian LHDs reported the greatest increase in per capita revenue (nearly $19 per person) and the highest per capita levels of expenditures ($39.93 per person) of all district county types.
- Urban LHDs reported almost no change in per capita expenditures (approximately 95 cents per person) from 2015 to 2017.

Table 6. Median Expenditures by County Type and Size, 2015 and 2017

Median Expenditures	2015		2017	
	Total	Per Capita	Total	Per Capita
Very Small & Small Appalachian (n=25)	$965,779	$30.95	$1,070,146	$39.43
Very Small & Small Rural Non-Appalachian (n=23)	$1,324,581	$36.04	$1,410,621	$39.22
Very Small & Small Suburban (n=7)	$1,562,116	$35.29	$1,719,005	$38.84
Very Small & Small Urban (n=2)	$714,159	$27.68	$736,275	$28.41
Medium & Large Appalachian (n=14)	$2,021,230	$25.36	$2,450,889	$30.50
Medium & Large Rural Non-Appalachian (n=9)	$2,076,104	$29.16	$2,541,653	$37.13
Medium & Large Suburban (n=12)	$4,526,452	$30.40	$4,755,871	$33.79
Medium & Large Urban (n=10)	$6,045,641	$25.95	$7,211,159	$28.53
Very Large Urban (n=4)	$24,228,098	$45.38	$28,808,991	$50.24

Table 7. Median Revenue by County Type and Size, 2015 and 2017

Median Expenditures	2015		2017	
	Total	Per Capita	Total	Per Capita
Very Small & Small Appalachian (n=25)	$1,506,900	$43.61	$1,430,212	$54.15
Very Small & Small Rural Non-Appalachian (n=23)	$1,996,722	$50.39	$2,270,064	$64.97
Very Small & Small Suburban (n=7)	$2,671,954	$60.02	$2,835,800	$61.72
Very Small & Small Urban (n=2)	$781,177	$30.30	$783,749	$30.48
Medium & Large Appalachian (n=14)	$3,644,322	$38.39	$3,303,748	$43.25
Medium & Large Rural Non-Appalachian (n=9)	$3,313,192	$49.53	$4,062,039	$60.98
Medium & Large Suburban (n=12)	$7,069,855	$50.51	$7,627,112	$57.85
Medium & Large Urban (n=10)	$8,467,937	$36.39	$10,059,738	$38.37
Very Large Urban (n=4)	$31,089,066	$58.16	$38,152,939	$62.96

Tables 6 and 7 Key Information

- Very Small and Small Urban LHDs reported the lowest per capita expenditures in 2017.
- Very Large Urban LHDs reported the highest expenditures (both total and per capita) in 2017 of all LHDs, followed by Very Small and Small Appalachian and Rural, Non-Appalachian LHDs.
- Very Small and Small Rural, Non-Appalachian LHDs reported the highest per capita revenue in 2017.
- Very Small and Small Urban LHDs and Medium and Large Urban LHDs both reported the lowest per capita revenues.

Figure 6. Per Capita FTE By Pop Size Served, 2015 and 2017

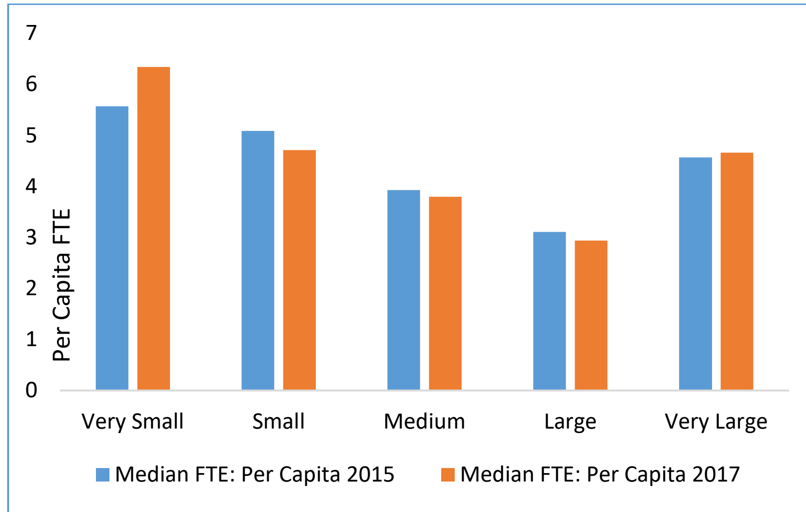


Figure 7. Per Capita FTE By County Type, 2015 and 2017

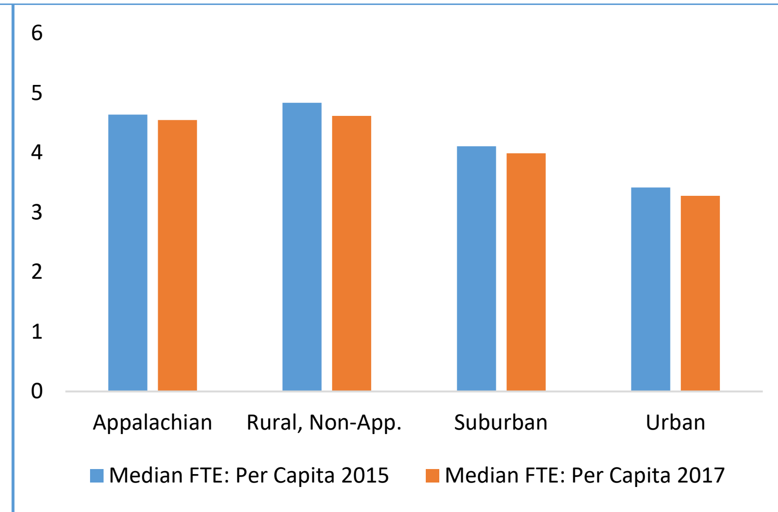


Figure 8. Median FTE By Size, 2015 and 2017

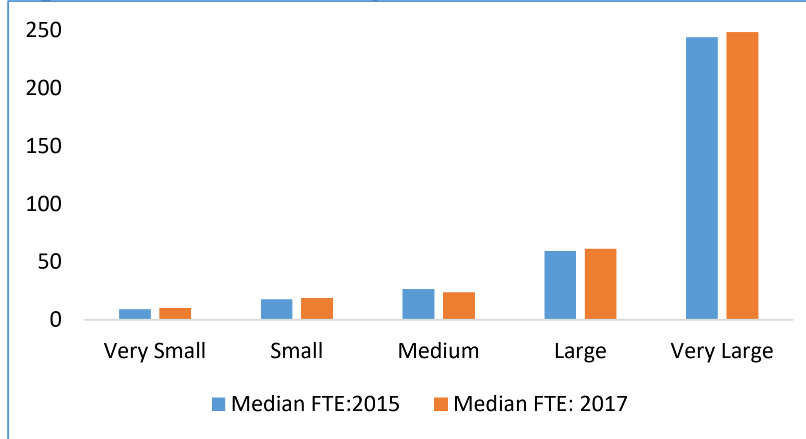
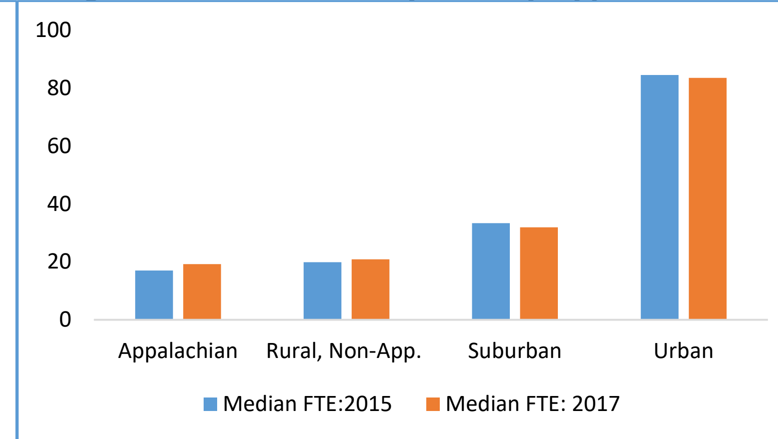


Figure 9. Median FTE By County Type, 2015 and 2017



Figures 6—9 Key Information

- Very Small and Very Large LHDs both increased their per capita FTEs between 2015 and 2017.
- Per capita FTEs by county type were reduced slightly in all four categories between 2015 and 2017.

Table 8. Median FTE by County Type and Size, 2015 and 2017

Median Expenditures	2015		2017	
	Total	Per Capita	Total	Per Capita
Very Small & Small Appalachian (n=25)	16.00	5.59	16.25	5.67
Very Small & Small Rural Non-Appalachian (n=23)	15.62	5.09	16.90	4.65
Very Small & Small Suburban (n=7)	24.60	5.35	23.70	5.35
Very Small & Small Urban (n=2)	10.22	3.99	10.23	3.99
Medium & Large Appalachian (n=14)	27.00	3.28	25.50	3.37
Medium & Large Rural Non-Appalachian (n=9)	32.73	3.93	32.30	4.41
Medium & Large Suburban (n=12)	54.91	3.88	45.19	3.80
Medium & Large Urban (n=10)	71.55	2.93	70.83	2.86
Very Large Urban (n=4)	244.24	4.58	248.66	4.66

Table 8 Key Information

- Medium and Large Urban LHDs had the lowest per capita FTE of all size/county type categories of LHDs, followed by Medium and Large Appalachian LHDs.
- The greatest changes in per capita FTEs were noted among:
  - Very Small and Small Rural LHDs with a decrease of 0.45 FTE
  - Medium and Large Rural Non-Appalachian LHDs with an increase of 0.48 FTE.
- No other notable changes were identified.

4. Summary and Acknowledgements

This revised report shows data from a variety of sources, focusing on comparing the change over time between the original accreditation readiness assessment conducted in fall 2016 and the re-assessment in winter 2018. Highlights include characteristics of local public health in Ohio across different accreditation stages, population size served and county type. While LHDs still have work to complete in order to meet state requirements for accreditation by 2020, the majority have begun the process and have advanced along the accreditation continuum over the past 18 months.

Smaller rural and Appalachian districts remain in the earlier stages of accreditation compared to larger more urban districts; however, they have also shown progress across the accreditation spectrum. Nearly all accreditation readiness questions show improvement over time, with the largest change seen in LHDs budgeting for the costs of accreditation. The lowest completion rates for readiness were related to internal LHD communications and planning, a process for ID/Review Documents, and electronic filing systems, all steps primarily corresponding to the "Pre-Application Stage" of accreditation readiness.

Further analysis will be completed over the next 18 months by the CPHP to identify additional factors that influence accreditation readiness and to study the processes that LHDs undergo to obtain accreditation.

For more information about this project, please see our project website: https://u.osu.edu/cphpaccreditationproject/. Or, contact Meredith Cameron, Program Director, at cameron.829@osu.edu.

Special appreciation to the following advisory group members who have been providing feedback on the project:

- Chad Brown – Licking County Health Department
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Appendix A: Methods

Data summarized in this report were derived from three sources, which are delineated below: a) assessment surveys, b) annual financial reports (AFR), and c) the OPPD.

Assessment and Re-Assessment Surveys: The primary data collection tools (accreditation readiness assessment and re-assessment) were administered through Qualtrics software. The 2016 survey instrument consisted of three sections (1. accreditation readiness, 2. training and technical assistance needs, and 3. LHD service provision). The 2018 assessment consisted of only sections 1 and 2 noted above. The first section contained general information questions, including accreditation intent and process status, and selected questions adapted from the PHAB Accreditation Readiness Checklists (available at http://www.phaboard.org/wp-content/uploads/National-Public-Health-Department-Readiness-Checklists.pdf). The second section included questions pertaining to LHD training and technical assistance needs related to PHAB accreditation prerequisite documentation.

The initial assessment survey was distributed in the fall of 2016 and the re-assessment survey was distributed during February of 2018. The re-assessment survey was distributed to 116 Health Commissioners via a link embedded into an explanatory e-mail from the CPHP. Two reminder e-mails were distributed during the fielding period (February 6 through February 23, 2018). A total of 112 responses were received (96.5% response rate). Data were downloaded on March 5, 2018 and analyzed using Microsoft Excel.

Annual Financial Reports: Secondary data were obtained from Ohio's Health Department Profile and Performance Database (OPPD) housed at the Ohio Department of Health. Annual Financial Reports and LHD full-time equivalent data were downloaded from OPPD in October 2016 and in March of 2018. Statistical analysis was performed in SAS and Microsoft Excel.

Improvement Standards: Data for select Improvement Standards were downloaded from the OPPD in November 2016 and in April of 2018. Information on the select PHAB *Standards and Measures*, Version 1.5 (2013) is available at http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf.

Comparative Analyses: For comparison purposes across assessment years, only data from the one-hundred and six (106) LHDs that participated in the assessment surveys both years (2016 and 2018) were included in the various analyses.

Appendix B: Population Size Served and County Type Groupings

Note: Changes to LHD categorization in this revision are:

- Galion City Health Department updated from Very Small, Small Appalachian to Very Small, Small Rural Non-Appalachian
- Fulton County Health department updated from Very Small, Small Rural Non-Appalachian to Very Small, Small, Suburban
- Kenton-Hardin Health Department updated from Very Small, Small, Suburban to Very Small, Small Rural Non-Appalachian
- Warren County Combined Health District updated from Medium, Large Suburban to Medium, Large Rural, Non-Appalachian

Very Small, Small, Appalachian: Adams County Health Department, Ashtabula City Health Department, Cambridge Guernsey County Health Department, Carroll County General Health District, Conneaut City Health Department, Coshocton City Health Department, Coshocton County General Health District, East Liverpool City Health District, Gallia County Health Department, Harrison County Health Department, Highland County Health Department, Hocking County Health Department, Holmes County General Health District, Ironton City Health Department, Jackson County Health Department, Marietta City Health Department , Meigs County Health Department, Monroe County Health Department, Morgan County General Health District, New Philadelphia City Health Department, Noble County Health Department, Perry County Health Department, Pike County General Health District, Portsmouth City Health Department, Salem City Health Department, Vinton County Health Department, Washington County Health Department

Very Small, Small, Rural, Non-Appalachian: Ashland City Health Department, Ashland County Health Department, Champaign Health District, Clinton County Health Department, Crawford County General Health District, Defiance County General Health District, Fayette County Health District, Galion City Health Department, Hancock Public Health, Henry County Health Department, Kenton-Hardin Health Department, Logan County Health District, Mercer County-Celina City Health District, Middletown City Health District, Morrow County Health District, Norwood City Health Department, Ottawa County Health Department, Paulding County Health Department, Preble County Public Health, Putnam County Health Department, Shelby City Health Department, Sidney Shelby County Health Department, Van Wert County Health Department, Williams County Health Department, Wyandot County General Health District

Very Small, Small, Suburban: Auglaize County Health Department, City of Kent Health District, Fulton County Health Department, Madison County-London City Health District, Piqua City Health Department, Union County Health Department, Warren City Health Department

Very Small, Small, Urban: Alliance City Health Department, Massillon City Health Department, Springdale City Health Department

Medium, Large, Appalachian: Ashtabula County Health Department, Athens City-County Health Department, Belmont County General Health District, Clermont County Public Health, Columbiana County General Health District, Jefferson County General Health District, Lawrence County Health Department, Mahoning County General Health District, Ross County Health District, Scioto County General Health District, Trumbull County Combined Health District, Tuscarawas County Health Department, Youngstown City Health Department, Zanesville-Muskingum County Health Department

Medium, Large, Rural, Non-Appalachian: Darke County General Health District, Erie County Health Department, Huron County General Health District, Knox County Health Department, Marion Public Health, Sandusky County General Health District, Seneca County General Health District, Wayne County Health Department, Warren County Combined Health District

Medium, Large, Suburban: Clark County Combined Health District, Delaware General Health District, Fairfield Department of Health, Geauga County Health District, Greene County Public Health, Lake County General Health District, Licking County Health Department, Medina County Health Department, Miami County Public Health, Pickaway County General Health District, Portage County Health Department, Wood County Health District

Medium, Large Urban: Allen County Combined Health District, Butler County Health Department, Canton City Health Department, Cincinnati Health Department, City of Hamilton Health Department, Cleveland Department of Public Health, Franklin County Public Health, Hamilton County Public Health, Lorain County General Health District, Stark County Health Department, Toledo Lucas County Health Department

Very Large, Urban: Columbus Public Health, Cuyahoga County Board of Health, Public Health - Dayton and Montgomery County, Summit County Public Health