

# National Indian Health Board



## **Tribal Public Health Accreditation Readiness Case Study: Chickasaw Nation**

Karrie Joseph, Deputy Director, Public Health Policy and Programs, National Indian Health Board

Sarah Price, Public Health Associate, National Indian Health Board

Robert Foley, Chief Program Officer, National Indian Health Board

Miranda Willis, Accreditation Coordinator, Chickasaw Nation Division of Research and Public Health

**AUGUST 2018**

## INTRODUCTION

---

Since 2008, The National Indian Health Board (NIHB), and the Public Health Accreditation Board (PHAB) have partnered in a national effort to improve public health practice in Indian Country. Public health accreditation, using the PHAB Standards and Measures, is intended to advance quality and performance within public health departments. In 2014, NIHB created the Tribal Accreditation Support Initiative (Tribal ASI), in partnership with the Centers for Disease Control and Prevention (CDC). The goal of Tribal ASI is to increase the readiness of Tribal health departments to undertake or achieve public health accreditation through the provision of sub-awards to Tribes and targeted capacity building assistance. To ensure the Tribal ASI program would meet its intended goal of increasing readiness, it would be necessary to adequately measure the awardees readiness for public health accreditation. However, no tool existed that was widely used, adapted or created specifically for the uniqueness of Tribal health departments, and likewise assessed for effectiveness. Such a tool would also have to be useful to the Tribal awardees and not just for the grantors.

Measuring readiness is a systematic way to analyze an organization's current ability to undertake a task or make a change<sup>i</sup>. The concept of readiness is important because it allows programs to identify their strengths and gaps in pursuing a change or initiative, and focus their efforts on improving readiness in these areas. Assessing readiness can be an important tool for public health accreditation, since at its core, accreditation is a tool for implementing agency-wide change, inserting quality improvement as a core pillar of a public health department's activities. Readiness assessments can identify potential barriers to success. Over time, they can also provide data on progress being made and evidence for which interventions are successful.

NIHB adapted the evidence-based Community Readiness Model (CRM) to an Accreditation Readiness Model (ARM) to fit this unique challenge of assessing readiness for public health accreditation in Tribal communities. This model was chosen for its known fit in Indian Country and that it accounts for the underlying dynamics of readiness for change such as leadership support, community climate and knowledge of the issue.

Chickasaw Nation is one of 20 Tribes who have been supported by NIHB's Tribal ASI and has used the ARM to help direct their public health improvement path. According to their Accreditation Coordinator, Miranda Willis, "We run on numbers and we like to see that improvement so we can gauge where we are at and where we are going." In fact, if it weren't for the feedback from ARM, and the ability to see their progress and guide their steps, Chickasaw stated that they might not have continued on their public health accreditation path.

## **BACKGROUND**

---

### **Tribes' Experience with Public Health Accreditation**

Across the country, American Indian and Alaska Native (AI/AN) federally recognized Tribes are becoming increasingly interested in the public health accreditation process. Like other health departments, Tribal health departments provide a variety of public health services to their communities, and strive to perform at the highest level. For Tribal health departments, public health accreditation has been described as an exercise in Tribal sovereignty and promoting a high standard of public health practice across Native nations. By pursuing accreditation, Tribes are recognizing the opportunity to improve their performance, increase the quality and efficiency of their services, gain credibility and recognition for the work they do as well as bolster staff pride. Public health accreditation empowers Tribes in their inherent right to protect and promote the health of their citizens.

Despite the advantages, Tribes face unique challenges in pursuing accreditation. Public health services within Tribes often are situated in the Community Health Program but can be spread out among several Tribal departments or programs, and are often integrated with the clinical health system. Distinguishing public health functions from the larger health system may not be so clear. Infrastructure funds are generally pieced together from Indian Health Service agreements, Tribal funds, and competitive grants, making public health funding less stable and reliable than what a state or county relies upon. There may be little knowledge in the communities about public health as a field distinct from healthcare, and education is a necessary step to shift the focus from healthcare to public health in order to secure buy in. Governing entities and organizational structures vary widely by Tribe, so tailored approaches are necessary. A one-size fits all model is unrealistic.

### **Community Readiness Model (CRM)**

#### *History and Uses of the Community Readiness Model:*

Researchers at Colorado State University developed the CRM in the mid-1990s as a byproduct of different projects examining substance use prevention in rural communities. Community readiness is the degree to which a community is ready to take action on an issue. The model creates a framework for assessing a community and its resources in regards to a particular issue and how prepared, motivated, and committed a community is to creating positive change around that issue.<sup>iii</sup> The idea of individual readiness was illuminated by Prochaska and DiClemente's Transtheoretical Model of Change. The CRM draw's from DiClemente's staged approach of readiness, and similarly has theoretical roots in Rogers' decision-making frameworks<sup>iv</sup> and community development frameworks posed by Warren.<sup>v</sup>

The CRM is predicated on beliefs that

- readiness is measurable,
- readiness is multi-dimensional and can vary from dimension to dimension,
- action to increase readiness or address a communal concern must be aligned to a community's level of readiness, and that such action can be equally multi-faceted.

Using the CRM encourages the use of local experts and resources instead of reliance upon outside experts and resources, which is helpful in Tribal communities as it promotes community recognition and ownership of the issue. Because of strong community ownership, it helps assure that strategies are culturally congruent and sustainable.<sup>vi</sup>

The process of community and organizational change can be complex and challenging, but the model breaks down the process into a series of manageable steps. The CRM is a nine stage spectrum of readiness across six dimensions. The model uses a standardized, yet highly adaptable, qualitative instrument to assess key informants within a community or organization across six different dimensions: Community Efforts, Community Knowledge of the Efforts, Community Climate, Leadership, Community Knowledge of the Issue, and Resources.

#### *Application of the CRM Model for Public Health Accreditation:*

Since its inception, the CRM model has been applied to a variety of different public health issues that require a collective approach in order to create sustainable change – methamphetamine use, alcohol abuse, inhalant abuse, suicide, dog bite prevention, and HIV, just to name a few. Innovative application of the CRM have utilized the framework and applied it to issues of organizational concern, such as assessing an organization's readiness to make broad change internally or using it as a strategizing tool to discover where an organization may need to focus efforts in order to increase the uptake of efforts, either internally or externally.

#### **Accreditation Readiness Model**

NIHB adapted the CRM to create the ARM in order to develop a tool that is relevant for Tribal health departments to measure their progress towards accreditation. This tool has been used by all Tribal ASI grantees as a guide for their activities, assessing their needs, and planning their timeline in pursuing public health accreditation.

#### *Adaptation of the Model:*

If community readiness is the degree to which a community is ready to take action on an issue, accreditation readiness can be described as the degree to which a public health entity is ready to apply for and achieve public health accreditation. NIHB adapted the CRM to a Tribal public health ARM framework in order to monitor smaller scale progress of Tribal health department sub-

awardees during the Tribal ASI project periods. The framework includes the same basic six dimensions and nine stages of readiness that appear in CRM, however, the dimensions are adapted to align with key indicators and milestones of public health accreditation work. The stages are also renamed to align with existing and accepted indicators of progress in public health accreditation (Table 1).

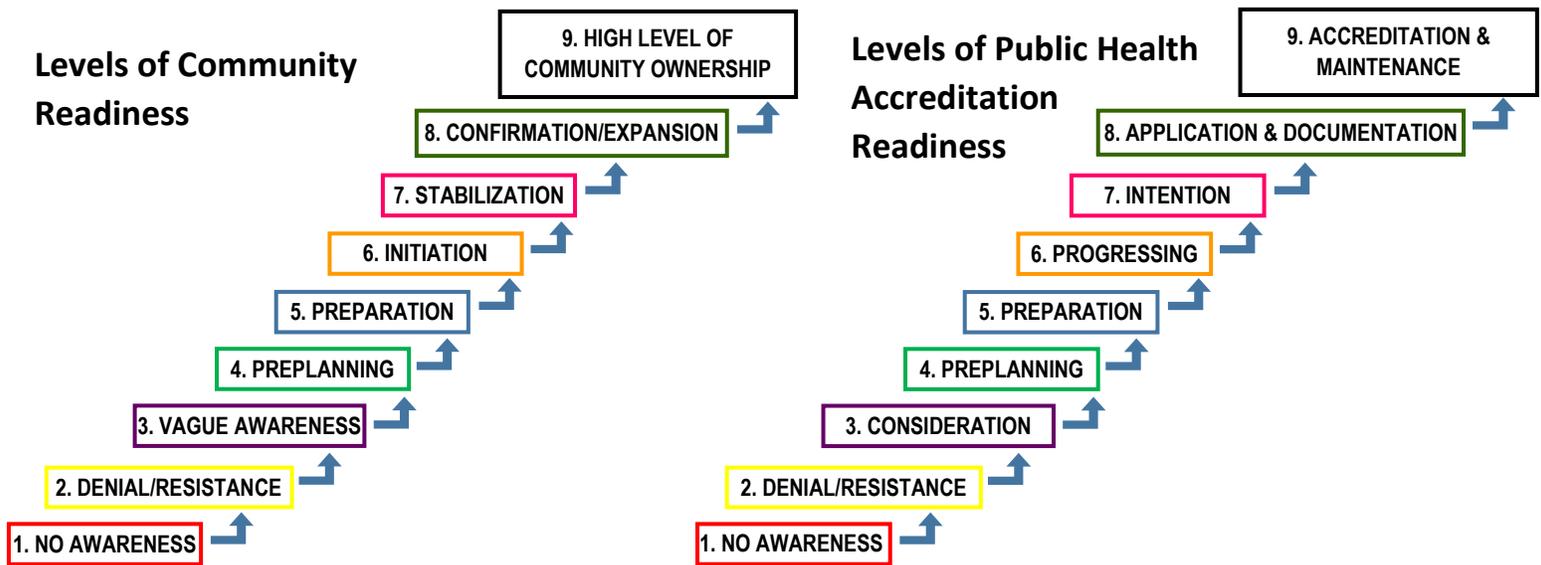
**Table 1: Comparing Community Readiness and Accreditation Readiness**

<b>Community Readiness Model</b>	<b>Public Health Accreditation Readiness Model</b>
A: Community Efforts - How much does the community know about the current programs and activities?	A: Public Health Accreditation Efforts – To what extent are there activities, efforts, programs, and policies that address public health accreditation?
B: Community Knowledge of the Efforts - To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?	B: Knowledge of Public Health Accreditation Efforts – To what extent do general staff and health department administration know about public health accreditation efforts, progress, and effectiveness?
C: Community Climate - What is the prevailing attitude of the community toward the issue? Is it one of helplessness or one of responsibility and empowerment?	C: Climate – What is the prevailing attitude of the general health department staff toward public health accreditation? Is it one of helplessness or one of responsibility and empowerment?
D: Leadership - To what extent are appointed leaders and influential community members supportive of the issue?	D: Leadership – To what extent are appointed and/or elected leaders and influential community members aware and supportive of public health accreditation?
E: Community Knowledge of the Issue - How much does the community know about the issue?	E: Community Knowledge about Public Health Accreditation - To what extent do community members know about accreditation activities, the purpose and courses of action, and how it may impact the community?
F: Resources - To what extent are local resources – people, time, money, space, etc. – available to support efforts?	F: Resources Related to Public Health Accreditation - To what extent are local resources – staff, time, money, space, storage, etc. – available to support accreditation efforts?

*Implementation of the Model:*

The model is implemented through a standardized set of questions, which are used during a key informant interview with members of a Tribal health department’s accreditation and leadership team. Following the interview, multiple reviewers use a standardized key to score participant readiness on a scale of 1-9 in each category based on the qualitative data collected. These scores are based on a scale adapted from the CRM to reflect different stages of readiness (Table 2). These scores are compared and averaged by the reviewers to determine a final score.

*Table 2: Levels of Readiness*



Each Tribal ASI sub-awardee engages in a pre and post accreditation readiness assessment during each grant cycle. Over the course of a few grant cycles, sub-awardees are able to track their progress in making strides towards increasing accreditation efforts, improving knowledge of accreditation among health department staff, creating a positive climate for accreditation, increasing leadership involvement, educating and partnering with the community, and securing resources. This tool has been used by all the sub-awardees of the Tribal ASI grant, including Chickasaw Nation who used the results to focus their efforts.

**Chickasaw Nation’s Journey towards Public Health Accreditation**

The Chickasaw Nation has been interested in pursuing public health accreditation since 2013, and in 2016 they formally began their journey. Using funding and resources from the 2015-2016 NIHB’s Tribal ASI grant, the Chickasaw Nation Department of Health (CNDH) developed an internal team, developed an accreditation work plan, assembled a cross-sector public health stakeholder workgroup and began work on a community health assessment. The community health assessment was completed in December 2016 and the community health improvement plan was completed in 2017. In 2017, the CNDH assessed the public health competencies of the Division of Research and Public Health (DRPH) staff and then developed a workforce development plan to address the identified gaps. The FY 2018 plan focused on creating a branding strategy and public health communication plan. The Chickasaw Nation also was able to appoint an accreditation coordinator during the grant year due to the Tribal ASI grant, and allowed the Nation to announce their intent to apply for public health accreditation.

When viewing the CNDH journey simply as reaching the milestones of completing the required major plans and activities such as the Community Health Assessment and Workforce Development Plan, their journey may appear linear and methodical. When viewing their journey through the lens of the ARM, the underlying dynamics that allow for the accreditation work to not only be

completed, but more importantly, be successful, became apparent. Also apparent is the importance of reflecting on the underlying processes to gauge and inform the journey.

During a key informant interview, NIHB staff asked the representatives from the Chickasaw Nation to reflect on the changes in their scores over the grant years, and explain how this assessment affected their progress towards public health accreditation.

*"We run on numbers and we like to see that improvement so we can gauge where we are at and where we are going."*

Miranda Willis, Accreditation Coordinator

## CHICKASAW NATION'S RESULTS

---

### Overview

Between 2016 and 2018, the Chickasaw Nation underwent a number of accreditation readiness model assessments, one pre and post for each of the Tribal ASI's yearly award cycles. The results of the ARM assessments showed an overall improvement in public health accreditation readiness, with an increase from 4.58 to 6.48, a 1.9 point increase. The Chickasaw Nation increased their readiness in 5 out of 6 categories (*Table 3*).

### Improvements in ARM Dimensions

#### ***Dimension A: Public Health Accreditation Efforts:***

*(To what extent are there activities, efforts, programs, and policies that address public health accreditation?)*

Starting in 2016, as one of their first steps toward accreditation and deemed foundational to accreditation activities, the Chickasaw Nation established a public health accreditation stakeholder group. They brought together a diverse group of Chickasaw citizens, community members, and employees representing each department within the Chickasaw Nation, offering a myriad of unique and varied perspectives and ideas that are greatly beneficial to the accreditation process. The Chickasaw Nation utilized the ARM assessment to gauge whether or not the creation of the broad stakeholder group was a successful activity. Through completing pre and post readiness assessments, they increased their score in this dimension 0.75 points. This provided evidence that the stakeholder group worked. Today the public health accreditation stakeholder group continues to grow and evolve in both membership and public health accreditation capacity.

***Dimension B: Knowledge of Public Health Accreditation Efforts:***

*(To what extent do general staff and health department administration know about public health accreditation efforts, progress, and effectiveness?)*

During their first readiness assessment in 2016, the Chickasaw Nation scored “knowledge of public health accreditation efforts” low on the readiness scale. At the time there were only four members of the public health department (known as the DRPH) who were aware of accreditation, all of whom would serve as members for the inaugural core accreditation team for the Chickasaw Nation. After identifying this category as an opportunity for improvement, the core accreditation team worked on educating other internal team members on the basic principles of public health and public health accreditation. Once the internal team members were comfortable and confident with the subject matter, they then joined the core accreditation team and many would eventually become domain team leaders for the larger accreditation stakeholders group. As the Chickasaw Nation continued to work towards accreditation, the public health accreditation stakeholders were assigned to domain teams based on their expertise, job experience, and interest. Each team works through one or more of the public health accreditation domains to identify and collect documentation or assist in the creation of any missing documentation. Upon completion of the post assessment survey, the Chickasaw Nation noted that overall the knowledge of public health accreditation efforts increased and continues to increase with each year as accreditation efforts supported by Tribal ASI and internal funding continue. The success of incorporating public health and public health accreditation education for internal employees has resulted in the Chickasaw Nation’s DRPH to include public health and accreditation-related trainings as core part of the division’s onboarding process, and is ingrained in the way they conduct activities.

***Dimension C: Leadership:***

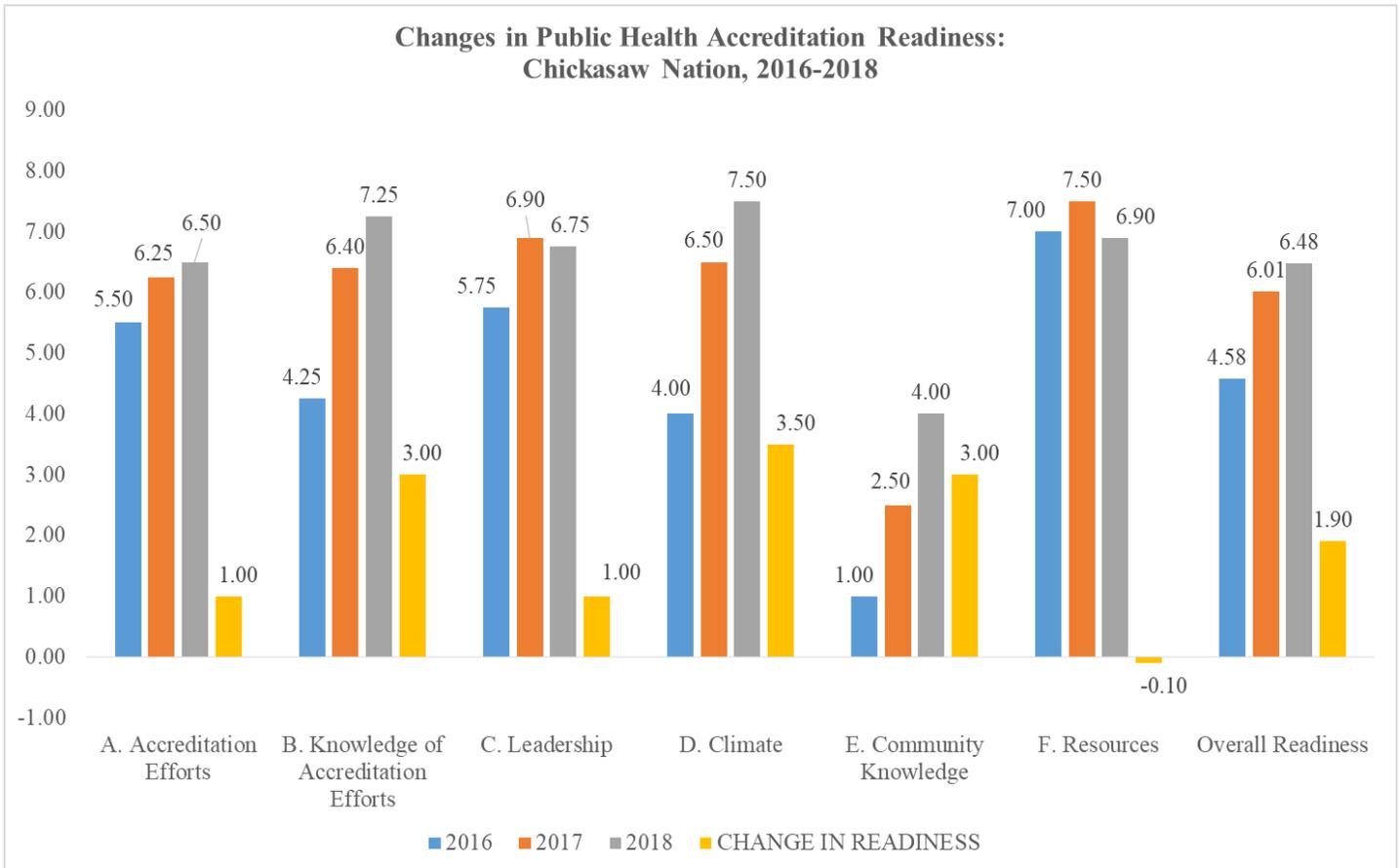
*(To what extent are appointed and/or elected leaders and influential community members aware and supportive of public health accreditation)*

From 2013 to 2015, the DRPH leadership worked with the CNDH’s leadership to gain the necessary support to actively pursue accreditation. In addition to DRPH’s efforts to gain leadership support, the CNDH leadership including the Undersecretary of Health was an active member of public health stakeholder group. The Undersecretary of Health also began to attend the core accreditation team meetings to stay informed on the processes. These efforts significantly increased leadership involvement in the overall accreditation process.

The leadership knowledge indicator did drop during FY 2017, due to a transition in the Department of Health leadership. However, using the ARM tool, the Chickasaw Nation DRPH identified this decrease and recognized it as an opportunity to educate new leadership on the accreditation process by including them in the stakeholder group, and potentially

the core accreditation team meetings. They continue to invite new leadership to the core and stakeholder meetings, and provide monthly updates to leadership. They are expecting to see an increase in leadership this year, and are incorporating new tools, such as the NIHB elevator speech tool to develop a focused message.

**Table 3: Chickasaw Nation Changes in Public Health Accreditation Readiness, 2016-2018**



**Dimension D: Climate:**

*(What is the prevailing attitude of the general health department staff toward public health accreditation? Is it one of helplessness or one of responsibility and empowerment?)*

The Chickasaw Nation knew that in order to successfully achieve accreditation, engagement from all internal staff and external stakeholders was essential. Everyone needed to be on board and excited to pursue accreditation. At the beginning of their accreditation journey, internal staff and external stakeholders voiced their concerns about pursuing accreditation. Many felt overwhelmed by the accreditation process and were unsure about time and resource commitment the process would require. The DRPH worked over the following years to ease the uncertainties regarding the accreditation process by choosing to focus on how the process would help strengthen and improve services, rather than creating additional work. Another barrier that initially hindered the climate surrounding accreditation was the misperception of public

health services. The DRPH worked with the stakeholders to raise awareness on how their jobs contribute to the public health system of the Chickasaw Nation. In addition to the addressing the internal staff and stakeholders' concerns about accreditation, their partnership with Cherokee Nation, the first Tribal public health system to achieve accreditation, and resources such as the NIHB *Tribal Leader's Perspectives on Public Health Accreditation* video were great inspirations as the Chickasaw Nation moved forward with their accreditation efforts. Trust was built and buy-in was obtained among the stakeholders, resulting in the Chickasaw Nation seeing the most substantial growth in this category, increasing by 3.5 points. The substantial growth in this category indicated to the Chickasaw Nation that such strategies are successful ways to ensure engagement in public health and public health accreditation activities and they plan to continue to incorporate strategies as they continue with the accreditation process.

***Dimension E: Community Knowledge about Public Health Accreditation:***

*(To what extent do community members know about accreditation activities, the purpose and courses of action, and how it may impact the community?)*

As with many Tribes who participate in ARM assessments, community knowledge of accreditation is a challenge for the Chickasaw Nation. They have been working to mitigate this through various policies and procedures. CNDH and DRPH managed to increase their score by 3 points by engaging with the Chickasaw Nation Department of Communications early on. The Chickasaw Nation Department of Communications is the primary source for providing information to all Chickasaw Nation citizens and other community members. Since being invited to the public health accreditation stakeholder meetings, this department has become extremely involved in the accreditation process and has attended every meeting since. The DRPH works directly work with the communications officer to increase communication to the community. The executive officer of the health department has established quarterly meetings to discuss public health issues.

Although they have been able to increase their score for this category continuously throughout the Tribal ASI funding cycles, the Chickasaw Nation decided to utilize the most recent Tribal ASI funding to continue to improve their score. The most recent funding was used to create a branding strategy and public health communication plan for the DRPH, in collaboration with the Department of Communications. The branding strategy and communication plan ensures that all Chickasaw communication has the same style, and that all information provided to the public is in clear and simple language. DRPH also plans to implement NIHB's Tribal ASI elevator speech tool to create simple messages for the community to further increase community knowledge. The Chickasaw Nation expects to see this category increase as they continue to progress through the accreditation process.

### ***Dimension F: Resources Related to Public Health Accreditation:***

*(To what extent are local resources – staff, time, money, space, storage, etc. – available to support accreditation efforts?)*

The Chickasaw Nation started with a high score in the resources category, as they had staff dedicated to accreditation and the Tribal ASI grant. This score increased as more time was devoted to accreditation, and an accreditation coordinator position was established. A large accreditation grant cycle recently ended, resulting in a slight reduction in their score.

### **Chickasaw Nation’s Overall Experience**

With the feedback from the ARM assessments, the Chickasaw Nation has been able to continue their accreditation journey. The accreditation coordinator stated that the Chickasaw Nation emphasizes the importance of improvement throughout the Tribe. The ARM allowed the Chickasaw Nation to gauge their progress as they progressed through the accreditation process. The ARM’s measurable scale has been extremely beneficial for determining which strategies are the most effective to engage internal staff, external stakeholders, and leadership in the accreditation process. Additionally, internal planning benefits from targeting areas that need improvement, and determining the goals of the stakeholder group, including aligning resources and working together on areas that need more engagement. Even low scores are helpful for indicating what needs to be done to move forward with accreditation.

The Chickasaw Nation recommends this tool to others, including other Tribes, and State and Local Health departments, especially smaller organizations that are contemplating or are currently seeking public health accreditation.

## **DISCUSSION:**

---

### **Implications for Tribal Public Health**

This tool has proven to be invaluable for the Chickasaw Nation’s accreditation efforts, and similar feelings have been shared by other recipients of the Tribal ASI grant. The data provided is a measureable way to mark progress, assess needs, and make improvements over the course of implementing practices aimed at public health accreditation. Furthermore, Chickasaw Nation’s focus on engaging diverse stakeholders directly stems from their use of the ARM. CRM, and ARM in turn both focus on engaging your community and partners throughout the process, and mobilizing the larger community and system for change by increasing their readiness. As Chickasaw Nation’s accreditation coordinator shared, “Often at local and State levels, the community piece is an afterthought rather than building it together. Tribes know that engaging

their community and building and planning together is the best way for system wide change, and that creating a supportive environment is as much a part of accreditation as securing the necessary documentation." Where we have often heard and observed that underlying organizational, leadership and community dynamics strongly factor in to a Tribe's success with new programs or initiatives. The Chickasaw Nation's journey with accreditation, measured by the ARM, support that assertion. This case study suggests that the CRM, when adapted for public health accreditation can be a useful, culturally appropriate tool for improving public health services across Tribal nations.

*"Tribes know that engaging their community and building and planning together is the best way for system wide change, and that creating a supportive environment is as much a part of accreditation as securing the necessary documentation."*

Miranda Willis, Accreditation Coordinator

### **Implications for Public Health Practice**

Public Health entities pursuing improvement efforts such as through public health accreditation, should consider using the ARM or adapting the CRM. Many public health programs gauge their progress with checklists and milestones. While valuable, relying solely upon them for measuring success may not be truly representative of growth and improvements or fully indicative of the challenges. ARM goes beyond, focusing and reflecting on the underlying processes. Knowledge and awareness, relationships, and attitudes are dimensions equally as important as meeting program milestones and contribute to strengthening a collaborative public health system. Using a tool such as the ARM for accreditation can measure and track the often unseen and unmeasured aspects of capacity growth that are necessary for improving public health performance.

### **RESOURCES**

---

<sup>i</sup> U.S. Department of Health and Human Services Health Resources and Services Administration. *Readiness Assessment & Developing Project Aims*. Retrieved 7/6/2018 from <https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/readinessassessment.pdf>.

<sup>ii</sup> Public Health Accreditation Board. *What is Public Health Accreditation*. Retrieved 7/6/2018 from <http://www.phaboard.org/accreditation-overview/what-is-accreditation/>.

<sup>iii</sup> Oetting, E.R., Plested, R.W., Edwards, P.J., Thurman, K., Kelly, J, Beauvais, F. Modified and expanded by Stanley, L.R. (2014). *Community Readiness for Community Change* (2<sup>nd</sup> Edition). Fort Collins: Tri-Ethnic Center for Prevention Research.

<sup>iv</sup> Rogers, E. M. (1983). *Diffusion of innovations*. New York: The Free Press.

<sup>v</sup> Warren, R. (1978). *The Community in America* (3d ed.), Chicago: Rand McNally.

<sup>vi</sup> Edwards, R.W., Jumper-Thurman, P., Plested, B.A., Oetting, E.R., Swanson, L. (2000). *Community Readiness: Research to Practice*. Tri-Ethnic Center for Prevention Research, Colorado State University. *Journal of Community Psychology*. 28(3); pgs. 291-397.