

WHITE PAPER NO. 3 · ORIGINAL RESEARCH · WORKFORCE SCIENCE & PRACTICE

Navigating Matrix Governance Without Line Authority

A Multi-Source Systematic Review and Job Task Analysis of 131 Public Health Accreditation Coordinator Position Descriptions (2009–Present)

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AccrediQI Academy · October 2026

131

position descriptions

42

states

1,694

duty statements coded

 $\kappa = 0.89$

coding agreement

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About this white paper

This paper reports Phase 1 of a national Job Task Analysis (JTA) of the public health Accreditation Coordinator: a systematic review and environmental scan of government position descriptions. It is White Paper No. 3 in the AccrediQI Academy White Paper Series; White Paper No. 2 sets out the case for the national JTA.

Methodological standards

PRISMA 2020 Statement; Uniform Guidelines on Employee Selection Procedures (EEOC, Civil Service Commission, DOL, DOJ, 1978); Standards for Educational and Psychological Testing (AERA, APA, NCME, 2014)

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Keywords

public health accreditation; PHAB; job task analysis; Accreditation Coordinator; workforce development; civil service classification; performance management; continuous quality improvement

SUMMARY

Abstract

Context. National voluntary accreditation administered by the Public Health Accreditation Board (PHAB) has become the principal structural mechanism for standardizing quality and Foundational Capabilities across the fragmented U.S. public health system. Despite the strategic importance of accreditation, no psychometrically grounded Job Task Analysis (JTA) has been conducted for the position responsible for orchestrating it: the Accreditation Coordinator (AC).

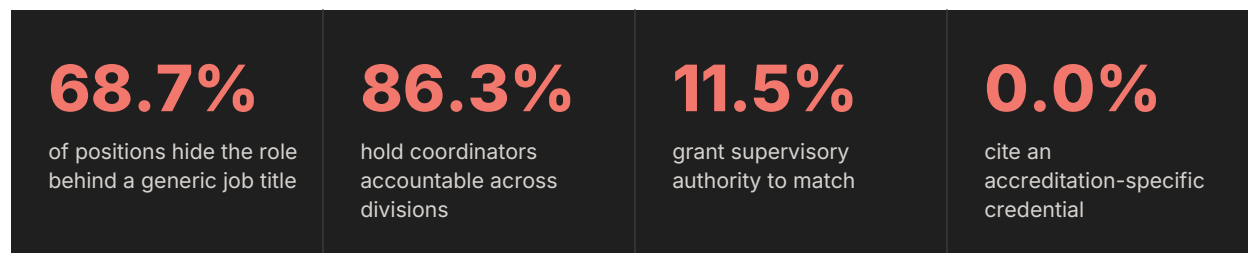
Objective. To establish an empirical baseline for a national JTA by systematically analyzing authentic state, local, tribal, and territorial (SLTT) Accreditation Coordinator job descriptions published from 2009 to the present.

Methods. Guided by PRISMA 2020 and the Uniform Guidelines, a multi-source search was conducted across specialized professional clearinghouses (NACCHO, ASTHO, ASPPH/PublicHealthJobs.org), state civil service and county personnel portals, departmental archives, and commercial employment aggregators (LinkedIn, Indeed, ZipRecruiter, Glassdoor, Google for Jobs). A four-stage screening protocol identified 131 authentic governmental classification specifications from 42 states. A standardized 44-variable abstraction matrix captured organizational taxonomy, compensation, reporting structure, minimum qualifications, and discrete task statements. The 1,694 extracted statements underwent natural language processing (NLP) frequency analysis and inductive semantic clustering.

Results. Of 1,985 records screened, 85.6% (n=1,700) were excluded as non-governmental, chiefly hospital accreditation (The Joint Commission) and higher education compliance; within commercial aggregators alone, the false-positive rate reached 92.3%. The retained sample (N=131) used 31 distinct job titles, and only 31.3% (n=41) carried an explicit accreditation title, reflecting widespread nomenclature masking. While 86.3% (n=113) of descriptions assigned cross-divisional accountability and deadline enforcement, only 11.5% (n=15) granted line supervisory authority. Semantic coding grouped the 1,694 duty statements into five functional domains: (1) Documentation Harvesting and Portal Administration (32.6%); (2) Performance Management and Domain 9 CQI (23.4%); (3) Cross-Divisional Facilitation and Strategic Diplomacy (18.2%); (4) Strategic Planning and CHA/CHIP Alignment (15.0%); and (5) Programmatic and Clerical Overflow (10.8%). Longitudinal analysis showed a shift from transactional document assembly in Era 1 (2009–2014; 47.8% of tasks) toward performance management, CQI, cross-divisional facilitation, and Foundational Capabilities in Era 3 (2022–present; 62.0% combined). Thematic saturation was reached at approximately 85 position descriptions, with no novel task categories emerging thereafter.

Conclusions. Accreditation Coordinators face a severe structural paradox: agencies demand executive-level organizational transformation, cross-departmental diplomacy, and performance management from junior- or mid-level classifications that lack supervisory authority and specialized training. These findings provide the foundational task inventory for a Phase 2 Subject Matter Expert DACUM workshop, civil service reclassification, and dedicated professional credentialing.

KEY FINDINGS



BACKGROUND

1 Introduction

For more than three decades, U.S. governmental public health has struggled to resolve the vulnerability first diagnosed by the Institute of Medicine (IOM, 1988): profound disparity across jurisdictions in operational capacity, service scope, and quality of protection. Rooted in constitutional federalism, under which police powers are reserved to the states by the Tenth Amendment, governmental public health evolved as a decentralized mosaic of more than 3,000 SLTT departments operating under widely divergent administrative, statutory, and fiscal arrangements (Turnock & Atchison, 2002; Wasserman et al., 2006).

The national voluntary accreditation program, launched by PHAB in 2011 and modernized through the Refreshed Standards & Measures (2026) and the Pathways Recognition program, is the most significant structural intervention designed to bridge this divide (PHAB, 2026). By establishing consensus-driven Foundational Public Health Capabilities (FPHC) that apply across centralized, decentralized, and hybrid jurisdictions, accreditation helps transform departments from isolated bureaucracies into data-informed learning organizations (DeSalvo et al., 2016; Erwin & Brownson, 2017). Federal investments, most notably the Centers for Disease Control and Prevention's (CDC) Public Health Infrastructure Grant (PHIG), increasingly tie institutional sustainability, operational transformation, and performance management to accreditation milestones.

1.1 The centrality of the Accreditation Coordinator

Health officers, boards of health, and elected commissioners authorize an agency's pursuit of accreditation, but the operational burden of leading the agency through a multi-year transformation falls on the Accreditation Coordinator, who serves as the central operational architect of the effort through four core functions:

Function	What it involves
Cross-divisional orchestration	Navigating program silos such as environmental health, maternal and child health, communicable disease epidemiology, and fiscal operations to build integrated workflows.
Operationalizing the Trajectory of Practice	Helping frontline staff see that routine service encounters, inspections, and clinical logs, once synthesized into public health intelligence and evaluated through feedback loops, are the authentic evidence national standards require.
Performance management and CQI leadership	Advancing PHAB Domain 9 by inventorying data streams, monitoring benchmarks, facilitating performance reviews, and coaching cross-functional teams through Plan-Do-Study-Act (PDSA) cycles.
External intermediation	Managing the submission lifecycle in PHAB's electronic system and serving as the primary liaison during peer-review site visits.

Prior evaluations indicate that an empowered, competent coordinator is among the strongest predictors of accreditation success, culture change, and workforce engagement (Carman et al., 2014; Kronstadt et al., 2016).

1.2 The workforce paradox and the empirical void

Despite the role's importance, the governmental public health enterprise exhibits a critical structural contradiction. Allied professions are supported by national competency models and specialized degrees: epidemiologists by the CDC/CSTE Applied Epidemiology Competencies, health educators by the NCHEC job analyses underlying CHES/MCHES, and environmental health specialists by NEHA's REHS/RS job analysis. No psychometrically grounded JTA has been performed for the Accreditation Coordinator.

Instead, health departments recruit, assign, and compensate coordinators through ad hoc, unvalidated position descriptions. Practice reports suggest agencies often treat accreditation as an entry- or junior-level responsibility, or attach it as an uncompensated collateral duty ("other duties as assigned") to junior health educators, planners, or administrative assistants (Mando, 2026). The result is an acute *authority deficit*: coordinators are expected to direct senior division chiefs and enforce organizational deadlines without supervisory rank or budgetary leverage, producing role ambiguity, administrative friction, and turnover.

1.3 Study objectives

To establish an evidence-based foundation for a national JTA consistent with the Uniform Guidelines on Employee Selection Procedures (EEOC, 1978), this study reports a Phase 1 systematic review and multi-source content analysis of SLTT Accreditation Coordinator job descriptions published from 2009 to the present. It addresses five research questions:

Table 1. Research questions

	Focus	Research question
RQ1	Taxonomy and nomenclature	What civil service titles, pay grades, and organizational ranks are assigned to the accreditation function, and to what degree is the role masked behind generic classifications?
RQ2	Structural leverage and authority	How do operational responsibilities, such as cross-divisional matrix accountability, relate to formal line authority?
RQ3	Prerequisites and credentials	What degrees, experience thresholds, and certifications do hiring jurisdictions require?
RQ4	Functional duty decomposition	What discrete tasks constitute the contemporary AC position, and how do they cluster into functional domains?
RQ5	Longitudinal migration and saturation	How has the role evolved across three accreditation eras (Version 1.0, Version 1.5, and Version 2022), and at what sample size does the task inventory reach thematic saturation?

APPROACH

2 Methods

2.1 Methodological framework and regulatory standards

This review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) statement (Page et al., 2021). Extraction and coding protocols were structured to meet the professional and legal requirements for job analysis in the Uniform Guidelines (EEOC, 1978) and the *Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 2014). Under these standards, valid workforce profiling requires isolating discrete, observable task statements and knowledge, skills, and abilities (KSAs) from authentic employment classifications rather than promotional summaries.

2.2 Multi-source retrieval strategy

To capture the full jurisdictional and historical breadth of the position, and to evaluate how search channel affects results, a dual-track retrieval architecture was used. The search window ran from January 1, 2009, coinciding with national field-testing of preliminary accreditation standards, to the present.

Table 2. Multi-source retrieval channels

Track 1: Specialized public health and civil service repositories	Track 2: Commercial employment aggregators
NACCHO Careers ASTHO Job Bank PublicHealthJobs.org / ASPPH State civil service commission registers Municipal and county HR job portals Direct SLTT department archives	LinkedIn Jobs Indeed.com ZipRecruiter Glassdoor Google for Jobs

Standardized Boolean query strings were adapted to each repository's indexing syntax:

("Accreditation Coordinator" OR "Public Health Accreditation" OR "Accreditation Manager" OR "Public Health Quality Improvement Coordinator" OR "Performance Management and Accreditation Coordinator")

Where civil service portals supported nested keyword searching, secondary queries probed classification specifications for accreditation duties embedded within generic series (e.g., Public Health Specialist II, Health Planner IV, Health Program Coordinator).

2.3 Screening and eligibility protocol

All retrieved records (N=1,985) were entered into an electronic screening register and evaluated against predefined criteria through two independent processes: an AI-assisted screen and a separate human review. Records were retained only when both evaluations agreed or, where they diverged, after human adjudication.

Table 3. Eligibility criteria

Inclusion criteria	Exclusion criteria
• Issued by a governmental SLTT public health agency in the United States • Assigns explicit responsibility for leading, coordinating, or maintaining PHAB accreditation, Pathways Recognition, or a state-based accreditation system • Contains a complete, itemized inventory of essential duties, reporting relationships, and minimum qualifications • Published or in active use between January 2009 and the present	• Industry conflation: hospital and clinical (The Joint Commission, CMS, Magnet); higher education (SACSCOC, HLC, CEPH); industrial and laboratory (ISO 9001/17025); behavioral health and ambulatory (CARF, AAAHC) • Truncated recruitment summaries of three to five bullets • External consultant scopes of work and technical assistance RFPs • Duplicates re-posted across fiscal years or platforms

2.4 Data extraction and abstraction matrix

Retained position descriptions (N=131) were abstracted using a standardized 44-variable matrix organized into four categories:

Category	Variables captured
Jurisdictional and administrative	Jurisdiction type (LHD metro [>250,000], LHD medium [50,000–250,000], LHD small/rural [<50,000], state health agency, tribal health organization); governance type (decentralized/home rule, centralized/state-run, shared/mixed, sovereign tribal); region; era (Era 1: 2009–2014; Era 2: 2015–2021; Era 3: 2022–present)
Structural classification and placement	Civil service title; FTE allocation (dedicated 1.0, dual-role 0.50–0.75, collateral <0.50); reporting distance from the health officer (Levels 1–4); supervisory span of control; salary range
Prerequisites and qualifications	Minimum and preferred education; years of experience; named certifications (CPH, CHES/MCHES, PMP, Lean Six Sigma)
Task statement inventory	Verbatim duty statements, normalized through NLP tokenization and verb-object decomposition (e.g., " <i>Convene</i> [verb] cross-divisional accreditation steering committees [object] on a monthly basis [context]")

2.5 Coding reliability and saturation modeling

A randomly selected 20% subsample (n=26) was double-coded independently, once through AI-assisted coding and once by a human investigator. Inter-coder agreement (Cohen's kappa) was $\kappa=0.89$ overall, indicating almost-perfect agreement across jurisdictional, organizational, and domain categories. Discrepancies were resolved by human adjudication.

Thematic saturation was assessed by tracking the cumulative emergence of novel task codes and unique verb-object stems across the chronological sequence of analyzed descriptions (Guest et al., 2006; Hennink & Kaiser, 2022). Saturation was defined as ten consecutive descriptions yielding no novel task categories or functional sub-clusters.

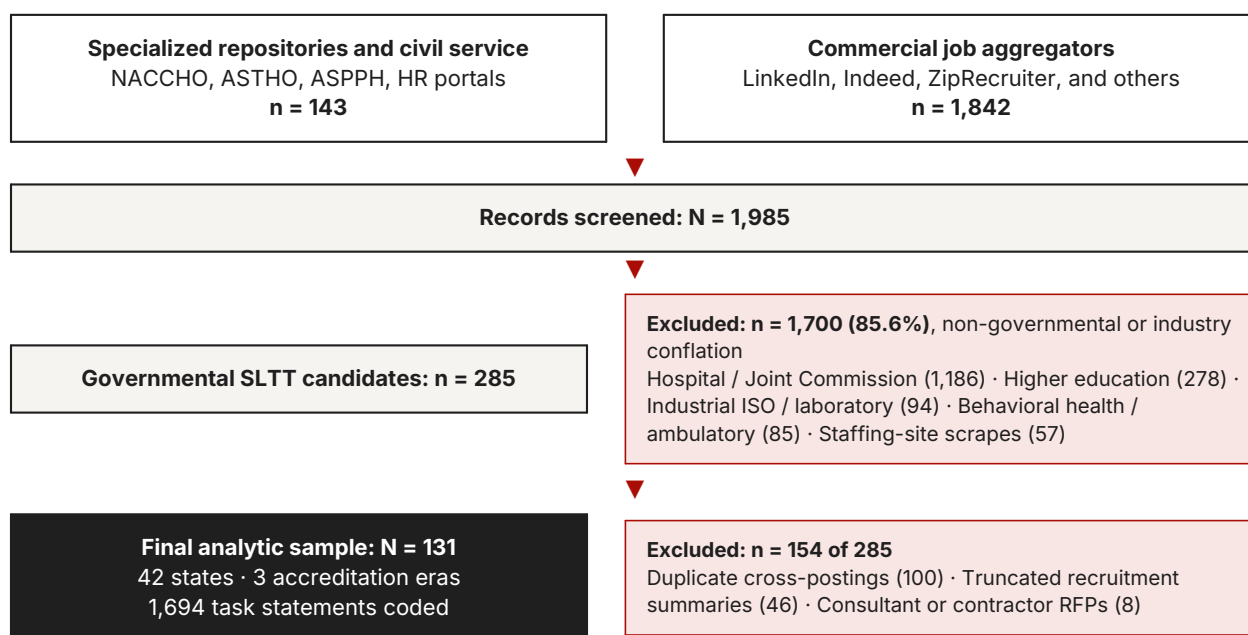
FINDINGS

3 Results

3.1 Retrieval funnel and PRISMA flow

The search yielded 1,985 records. Commercial aggregators showed a collapse in precision: 92.3% of their 1,842 records (n=1,700) concerned hospital care, higher education, or industrial quality control. They also exhibited severe recency truncation, with 96.4% of candidate listings posted within the preceding 90 days. After screening, commercial sources contributed only 19 unique governmental descriptions; the remaining 112 came from specialized public health clearinghouses and civil service archives. Figure 1 summarizes screening and attrition.

Figure 1. PRISMA 2020 flow diagram of search attrition



3.2 Jurisdictional stratification

The analytic sample of 131 governmental classification specifications provides broad geographic, governance, and longitudinal coverage (Table 4). Departments in 42 states are represented, limiting the influence of any single state's civil service conventions on the national baseline.

Table 4. Sample stratification (N = 131)

Stratum / category	n	%	Cumulative %
Jurisdiction type			
Local health department, large/metro (>250,000)	42	32.1	32.1
Local health department, medium (50,000–250,000)	44	33.6	65.7
Local health department, small/rural (<50,000)	24	18.3	84.0
State health agency	16	12.2	96.2
Tribal health organization	5	3.8	100.0
Governance structure			
Decentralized / home rule local board	75	57.3	57.3
Centralized / state-clustered unit	26	19.8	77.1
Shared / mixed governance	25	19.1	96.2
Sovereign tribal governance	5	3.8	100.0
Historical era			
Era 1: Version 1.0 launch (2009–2014)	31	23.7	23.7
Era 2: Version 1.5 and reaccreditation (2015–2021)	47	35.9	59.6
Era 3: Version 2022 and Pathways (2022–present)	53	40.5	100.0

3.3 Organizational taxonomy and nomenclature masking

The 131 descriptions used 31 distinct job titles, grouped into eight classification categories (Table 5).

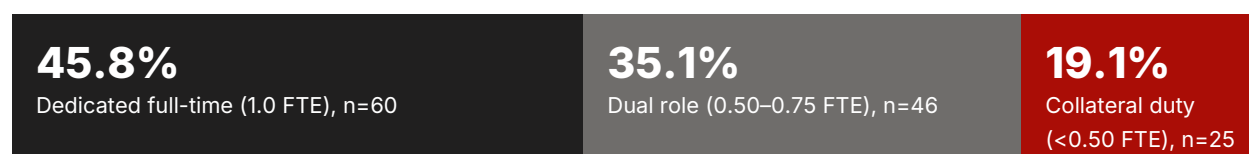
Table 5. Civil service nomenclature and title taxonomy (N = 131)

Title classification category	n	%	
Standalone Accreditation Coordinator / Accreditation Manager	41	31.3	
Performance Management & Quality Improvement Specialist	28	21.4	
Public Health Planner / Strategic Initiatives Coordinator	20	15.3	
Health Educator / Community Health Specialist (with accreditation duties)	18	13.7	
Epidemiologist / Informatics Analyst (with accreditation duties)	9	6.9	
Administrative Assistant / Office Specialist (with accreditation duties)	6	4.6	
Deputy Director / Assistant Health Officer / Division Director	5	3.8	
Grant Administrator / Operations Specialist (hybrid)	4	3.1	

Only 31.3% (n=41) of positions carried a standalone title containing "Accreditation." In the remaining 68.7% (n=90), the function was masked behind generic civil service classifications. In small and rural departments (<50,000 population), masking rose to 87.5% (21 of 24), with accreditation coordination typically embedded in existing Health Educator, Public Health Nurse, or Office Manager classifications.

3.4 FTE allocation and matrix authority

Structural commitment to the role varied considerably:

Figure 2. FTE allocation to the accreditation role (N = 131)

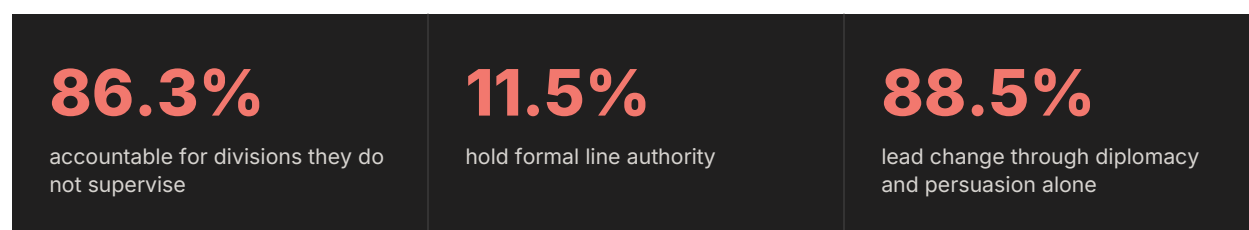
Most coordinators (71.0%) report to executive or senior leadership (Table 6).

Table 6. Reporting level of the coordinator (N = 131)

Reporting level	Reports to	n	%
Level 1: Executive direct	Public health director / health officer	51	38.9
Level 2: Senior management	Deputy director / division director	42	32.1
Level 3: Middle management	Program manager / section supervisor	31	23.7
Level 4: Operational staff	Lead sanitarian / senior specialist	7	5.3

Cross-tabulating reporting level with supervisory authority, however, revealed a profound structural divergence, the **authority deficit**:

- **Matrix accountability mandate.** In 86.3% (n=113) of descriptions, the coordinator is explicitly charged with "directing," "holding divisions accountable for," "auditing," or "enforcing" documentation deadlines and performance metrics across autonomous divisions such as environmental health, clinical services, vital statistics, and emergency preparedness.
- **Absence of line authority.** Only 11.5% (n=15) of coordinators hold formal supervisory authority over the staff, clinic managers, or epidemiologists responsible for producing evidence.



The structural result: 88.5% of coordinators drive department-wide transformation and standards conformity in a matrix structure, relying entirely on informal diplomacy, personal capital, and lateral persuasion.

3.5 Educational requirements and credentialing landscape

Table 7. Minimum and preferred educational thresholds (N = 131)

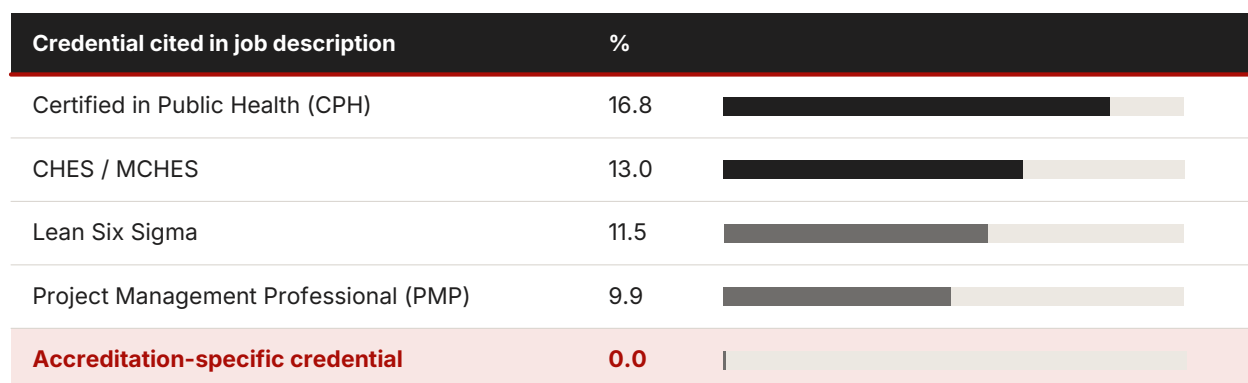
Educational level	Minimum (%)	Preferred (%)	n (minimum)
High school diploma / associate degree	5.3	0.0	7
Bachelor's degree (any field)	20.6	3.8	27
Bachelor's degree in public health / health	35.1	15.3	46
Master's degree (MPH / MS) required	35.9	58.0	47
Doctoral degree (DrPH, PhD, MD) required	3.1	7.6	4

Note. Preferred percentages sum to 84.7%; the remaining 15.3% of descriptions stated no preferred qualification.

More than one-third of positions (35.9%) required a master's degree at entry, and 62.7% of positions with a bachelor's minimum listed an MPH, MPA, or MHA as strongly preferred. Experience requirements concentrated in the mid-career range: 0–2 years, 26.7% (n=35); 3–5 years, 54.2% (n=71); and more than 5 years, 19.1% (n=25).

Certification requirements revealed a credentialing void. Descriptions occasionally cited allied credentials, including Certified in Public Health (CPH; 16.8%), CHES/MCHES (13.0%), Lean Six Sigma (11.5%), and Project Management Professional (PMP; 9.9%), but none (0.0%) cited an accreditation-specific credential. No nationally recognized designation currently certifies competence in public health accreditation coordination.

Figure 3. Credentials cited in Accreditation Coordinator job descriptions (% of 131)



3.6 Semantic task inventory

Inductive semantic coding and verb-object analysis of the 1,694 duty statements produced five functional domains comprising 19 operational sub-clusters (Table 8).

Table 8. Functional task domains and sub-clusters (1,694 statements)

Domain and sub-clusters	n	%	Core verbs
1. Documentation harvesting and PHAB portal management 1.1 Auditing documents for date, narrative, and signatory requirements 1.2 Redacting confidential and client-identifying information 1.3 Managing electronic submission staging and file naming 1.4 Pre-submission narrative synthesis and evidence mapping	552	32.6	Collect, vet, redact, upload
2. Performance management and Domain 9 CQI 2.1 Cataloging operational and surveillance data streams 2.2 Updating executive performance dashboards against strategic targets 2.3 Coaching division teams through PDSA cycles 2.4 Facilitating agency-wide quality improvement committees	397	23.4	Benchmark, monitor, facilitate, improve
3. Cross-divisional facilitation and strategic diplomacy 3.1 Leading internal accreditation steering committees 3.2 Translating PHAB standards into program-specific workflows 3.3 Mediating inter-divisional resistance and timeline compliance 3.4 Staff onboarding, training, and accreditation coaching	308	18.2	Convene, lead, negotiate
4. Strategic planning and CHA/CHIP alignment 4.1 Coordinating community health assessments (CHA) 4.2 Facilitating multi-sector community health improvement plans (CHIP) 4.3 Authoring strategic plans and Foundational Capability maps 4.4 Tracking workforce development plan (Domain 8) implementation	254	15.0	Author, align, synthesize
5. Programmatic and clerical overflow ("garbage can" domain) 5.1 Recording Board of Health meeting minutes 5.2 Writing routine categorical grant narratives 5.3 Maintaining department website and public information releases	183	10.8	Record, file, draft
Total	1,694	100.0	

3.7 Longitudinal role migration across accreditation eras

Cross-tabulating task frequencies by era reveals a substantial shift in the competencies demanded of the coordinator (Table 9).

Table 9. Longitudinal shift in functional task allocation (% of task statements)

Functional area	Era 1 (2009–14) n = 31	Era 2 (2015–21) n = 47	Era 3 (2022–present) n = 53
Transactional document harvesting	47.8	31.2	20.1
Performance management and Domain 9 CQI	14.1	22.9	28.7
Cross-divisional facilitation and diplomacy	11.6	17.0	22.4
Strategic planning and CHA/CHIP	12.3	16.5	17.9
Equity and Foundational Capabilities	3.1	5.2	10.9
Administrative and clerical overflow	11.1	7.2	0.0
Total	100.0	100.0	100.0

Note. For longitudinal comparison, equity and Foundational Capabilities statements are shown separately from the five-domain scheme in Table 8.

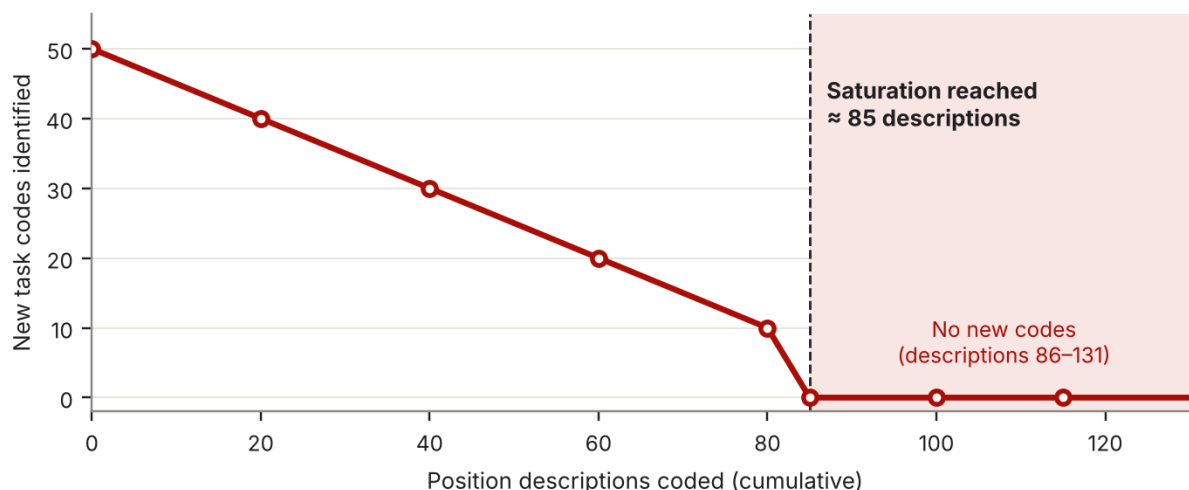
In Era 1, under preliminary Version 1.0 standards, the position was conceived primarily as an administrative archivist: nearly half (47.8%) of coded duties concerned physical and digital document harvesting ("collecting policies," "formatting file names," "assembling binders," "scanning PDFs"). By Era 3, under Version 2022 and Pathways Recognition, transactional collection fell to 20.1%, while performance management, CQI facilitation, cross-divisional diplomacy, and Foundational Capabilities rose to 62.0% of task statements. The contemporary coordinator functions as an internal management consultant responsible for organizational development, enterprise analytics, and systems change.

47.8% of duties were document gathering in Era 1 (2009–2014)	20.1% were document gathering in Era 3 (2022–present)	28.8% were leading improvement in Era 1	62.0% were leading improvement in Era 3
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3.8 Thematic saturation

Tracking code discovery across the sequence of analyzed descriptions confirmed that the sample reached thematic saturation (Figure 4). All five domains and 19 sub-clusters were fully delineated by the 85th description. Descriptions 86 through 131, including all 19 records contributed by commercial sources, yielded no novel task categories or unique action verbs; every statement mapped to an existing sub-cluster.

Figure 4. Emergence of new functional task codes across coded position descriptions



INTERPRETATION

4 Discussion

This systematic review is, to our knowledge, the first national empirical investigation of the governmental Accreditation Coordinator position. By synthesizing 1,694 duty statements from 131 classification specifications across 42 states, it reveals the structural tensions that shape accreditation leadership today.

4.1 Three workforce contradictions

The authority deficit

Accountability without leverage: 88.5% of coordinators enforce deadlines on senior division heads with no line, budget, or disciplinary authority.

Scope inflation

Strategic transformation work is commingled with routine clerical overflow, from PDSA facilitation to taking board minutes.

The competency void

Nearly 95% require at least a bachelor's degree, yet no curriculum or credential prepares people for the role.

The authority deficit: accountability without leverage. Agencies require coordinators to ensure department-wide conformity, convene steering committees, audit division files, and enforce submission deadlines on senior division heads, from environmental health directors to laboratory directors and nursing supervisors. Yet 88.5% of coordinators hold no line authority, and the descriptions grant no budgetary oversight or disciplinary leverage. Coordinators must therefore manage high-stakes, time-sensitive change entirely through diplomacy and persuasion, a structural defect that breeds conflict and burnout.

Scope inflation: the "garbage can" classification. High-level strategic work is commingled with routine clerical overflow (Domain 5). Coordinators are expected both to facilitate PDSA improvement cycles and to take Board of Health minutes, update web pages, or manage supplies. This pattern, consistent with the "garbage can" model of organizational choice (Cohen et al., 1972), reflects confusion over whether the coordinator is an executive change agent or an administrative clerk.

The untrained competency void. Nearly 95% of positions require at least a bachelor's degree, and 58.0% prefer a master's degree, yet no specialized curriculum or national credential prepares candidates for this role. CEPH-accredited MPH programs teach epidemiology, biostatistics, environmental health, and behavioral theory but offer little operational training in interpreting PHAB standards, harvesting evidence across divisions, or running enterprise performance management. Coordinators enter complex matrix roles with advanced degrees but little practical preparation.

4.2 Methodological limits of commercial job boards

A key methodological contribution of this study is its empirical test of retrieval architecture. Expanding the search to commercial aggregators showed they are structurally ill-suited to public health workforce research:

- **Clinical deluge (92.3% noise).** Commercial keyword algorithms conflate public health accreditation with hospital accreditation, clinical quality programs such as NCQA, and university accreditation. Filtering this noise requires aggressive exclusion rules that risk discarding small and rural departments.
- **Longitudinal erasure.** Commercial boards remove or paywall postings after 30 to 90 days. Scans relying on them alone produce severe recency bias, capturing Era 3 listings while erasing Eras 1 and 2.
- **Marketing summaries versus legal specifications.** Commercial postings compress formal classification specifications into short recruitment blurbs, omitting a large share of discrete duty statements. Sourcing directly from state and county civil service registers remains the only defensible approach for a psychometrically valid JTA.

4.3 Grounding in the Trajectory of Practice

The evolution documented across the three eras mirrors what AccrediQI Academy terms the **Trajectory of Practice**:

Figure 5. The Trajectory of Practice

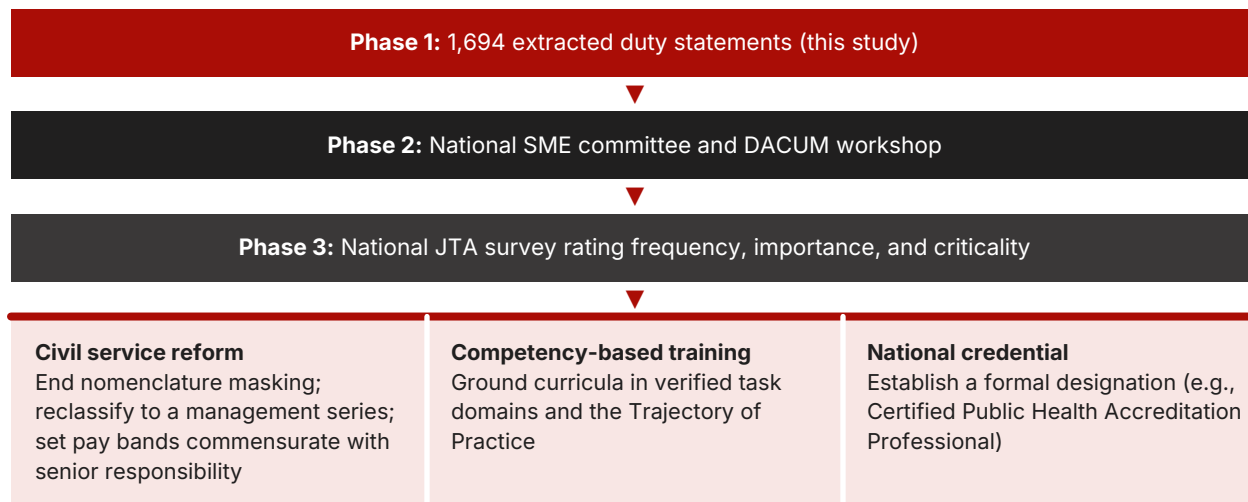


In Era 1, departments treated accreditation as a transactional compliance audit, searching for static paperwork weeks before deadlines. Era 3 descriptions reflect an institutionalized Trajectory of Practice: coordinators build mechanisms to continuously catalog data streams (Inquire), foster inter-divisional sense-making forums (Synthesize), translate intelligence into administrative and policy decisions (Formulate), and evaluate interventions through PDSA cycles (Actuate). Accreditation readiness becomes a byproduct of routine, high-performing practice rather than an episodic scramble.

4.4 Implications for policy, practice, and workforce development

The findings provide an actionable blueprint for national public health stakeholders (Figure 6).

Figure 6. Blueprint for national workforce reform



Phase 2 DACUM and national JTA. The 1,694 statements are the empirical substrate for Phase 2. The five domains and 19 sub-clusters will be condensed into a standardized inventory of 72 task statements for review by a national Subject Matter Expert panel in a structured DACUM (Developing a Curriculum) workshop.

Civil service reclassification. National leadership bodies, including PHAB, NACCHO, and ASTHO, can use this evidence to advocate classification reform. State and local civil service commissions should end the practice of grafting accreditation coordination onto entry-level

health educator or administrative positions. The role should be standardized within a management series (e.g., Public Health Performance and Accreditation Officer), report directly to the health officer, and carry a salary grade commensurate with senior administrative responsibility.

Curriculum design. Workforce initiatives such as AccrediQI Academy can use the five domains to build competency-based training focused on the friction points this study identifies: cross-divisional conflict mediation, evidence harvesting within routine workflows, Domain 9 performance tracking, and site visit preparation, rather than abstract lectures on standards.

Professional credentialing. The complete absence of accreditation-specific credentials (0.0%) signals an urgent opportunity. A nationally recognized certificate would formalize career pathways, reduce turnover, and give health officers objective evidence of a candidate's operational competence.

LIMITATIONS

5 Limitations

Several limitations warrant consideration. First, although the review captured 131 descriptions from 42 states, tribal health organizations (n=5) and small rural departments (n=24) were less represented than urban and medium-sized jurisdictions, reflecting the scarcity of published classification registers in resource-constrained settings. Second, written specifications capture institutional expectations and formal duties, which may diverge from the informal tasks coordinators perform in practice, particularly during emergencies such as COVID-19 reassignments. Third, position descriptions do not reveal how time is actually allocated across duties. Phase 3 of this JTA, a national survey of active coordinators, will directly measure task frequency, time allocation, and perceived criticality.

CONCLUSION

6 Conclusion

Accreditation has proven an indispensable catalyst for standardizing quality, advancing equity, and institutionalizing Foundational Capabilities across U.S. public health. Yet this infrastructure rests on an unsupported and structurally misaligned workforce.

Through a systematic review and content analysis of 131 authentic position descriptions, this study begins to fill the empirical void surrounding the Accreditation Coordinator. The data show that the position has evolved from administrative archivist to organizational strategist, a transformation that must now be matched by civil service reclassification, formal authority,

competency-based training, and national credentialing. Grounding the coordinator role in workforce science is a prerequisite for the long-term sustainability of the nation's public health infrastructure.

CORRESPONDENCE AND COLLABORATION

Coordinators, health officers, national partners, and researchers who would like to offer input or collaborate on Phases 2–4 are invited to get in touch.

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The Accreditation Coordinator has evolved from records keeper to organizational strategist. Classification, authority, and training must now catch up.

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