

Public Health Accreditation Update: Preparing for Version 1.5

CDC Performance Improvement Managers Network Call

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Today's Speaker: • Kaye Bender, PHD, RN, FAAN, President and Chief Executive Officer, Public Health Accreditation Board

Moderator: Melody Parker, CDC/OSTLTS

Operator: Welcome and thank you for standing by. Your lines are in listen-only mode until today's question and answer session. At that time, if you would like to ask a question you may do so by pressing star-1 on your phone. Today's conference is being recorded. If you have any objection, you may disconnect at this time. I would now like to turn the call over to Melody Parker. You may begin.

Melody Parker: Well, greetings and salutations everyone and welcome to the December Performance Improvement Managers Network (PIM Network) webinar. As you know, I am Melody Parker. I'm with the Office for State, Tribal, Local and Territorial Support (OSTLTS), and I'm joined here today by my very helpful colleagues from OSTLTS. So thanks for joining us today. This is the ninth and final call of 2013. As you know, the PIM Network is a community that supports all National Public Health Improvement Initiative (NPHII) performance improvement managers in learning from each other as well as from their partners and other experts. These calls give members of the Network a venue to learn about each other and share information about resources and training opportunities related to our work in quality improvement and performance management. Today we're going to be talking about the soon-to-be-released Version 1.5 of the Public Health Accreditation Standards and Measures. But before we dive in, let's first review some of the technological features of today's call.

On the LiveMeeting site today, you can see other sites that are participating in today's call by looking at the attendees under the link at the top left of your screen. You can also download reference documents and slides that were sent to you yesterday via the icon at the top right, and it looks like the little three tiny sheets of paper up there. We have two ways to facilitate the discussion today. First, we strongly encourage you to type in your questions and comments as we go at any time using the Q&A box, which you can find by clicking Q&A in the toolbar at the top of your screen. Second, we will open the lines for



discussion after our presenters have finished. Please mute your phone now either by using your phone's mute button or by pressing star-6 on your phone's keypad. Please note that we'll announce the identity of those submitting questions via LiveMeeting, but if you prefer to remain anonymous to the group in posing your question, please type anon either before or after your question. Today's call will last approximately one hour. The call is being recorded, and it will be archived on the OSTLTS PIM Network webpage.

Of course, we're going to want your feedback about today's event, so look for a poll at the end of the hour where you can tell us what you thought about the call today. Today on our call, we have Kaye Bender, who is the President and Chief Executive Officer of the Public Health Accreditation Board (PHAB), and she's been that since 2009. Because she will do me great bodily harm if I continue to read any more of her biographical information, which she swears you all know by heart, I'm going to put a sock in it here and turn it over to the good Dr. Bender. Kaye?

Kaye Bender: Thank you, Melody. Hello, everyone. Happy holidays. I think you should all get raises in your jobs for attending a webinar on accreditation this close to the holiday break, but thank you for being here. On our next slide, we'll look at the three areas that we plan to cover in this hour. We're going to share just a general update about where PHAB is, which will be very brief. We'll then move right into the Standards and Measures changes overview from Version 1.0 to 1.5, and then we'll dive into that a little bit deeper. Then we'll talk a little bit about how a health department decides which version that they want to use if they're close time-wise to making that application decision. I hope we'll have plenty of time for questions from you. My goal is to make sure that you understand where we're going with this next version, why we're going there, and most importantly, how it applies to your particular health department.

On this next slide I just wanted to give you a general update. We always like to talk about kind of where PHAB is in the overall scheme of things, so as of today we have a total of 248 health departments somewhere in the system. Twenty-two of those are accredited, and so that leaves about 220-ish that are somewhere in process, 226. Of those, 21 are states, 133 are locals, and there are two tribes, and we also have our first two applicants in our centralized states local health department integrated system category, and the second applicant is in our multi-jurisdictional category. Those are our first applicants in those accreditation categories that were created when we launched. We have a number of health departments that are moving through the system right now. We had site visits going on up until this week, and we'll pick right up right after the first of the year. I expect by the time our accreditation committee meets again that we will have quite a number of health departments who are being accredited. The work continues, and we're real pleased about that. We also, if you can believe it, are coming up on the first anniversary of accredited health departments. That means that they will be turning in their annual reports. As you may recall, when you're accredited, you're not done with PHAB. We have the requirement that there will be an annual report for every accredited health department, which is our way of keeping the momentum going around quality improvement (QI) and the relationship between accreditation and QI. The annual report is meaningful, but it's not as rigorous as the initial



accreditation review. We have a section like most accrediting bodies do where we ask for general updates and leadership changes, budget changes, anything that might affect the health department's ongoing conformity with the Standards and Measures. The rest of the report is about quality improvement, progress on the prerequisites, and that sort of thing. We'll begin those in early 2014, and you'll look forward in the future to hearing the great work that accredited health departments are doing.

Our board of directors met last week, and just some highlights from there. We have a new board chair, that's Les Beitsch. Many of you know Les. And our new vice-chair is Bud Nicola. Many of you know him as well. You'll see those names and faces as our new leadership. They've been on the board but they're new to those positions at PHAB. Of course, the reason we can do this webinar today is because our board did approve the final version of Version 1.5 of the Standards and Measures. You are the very first to hear in detail what that includes. I think it's very appropriate that you performance improvement managers and your staff are the first to hear what those changes entail, so we're very pleased that we were able to do that today.

We also updated our logic model that guides our evaluation of progress at PHAB, as well as a research agenda that hopefully, will guide researchers and evaluators to help us look at the difference that accreditation makes, the impact on health departments and that sort of thing. Most of those will very soon be posted on our website under the Research tab, if you're interested in those.

For our last update, I want to mention that the *Journal of Public Health Management and Practice* celebrates 20 years of publishing about what goes on in public health in this country, and they have chosen for their anniversary issue for January–February 2014 the topic of accreditation. The issue focus is actually entitled "Transforming Public Health Practice Through Accreditation." That issue is now out and available. We issued a press release about it last week. Thanks to the generosity of CDC funding, you don't have to be a subscriber to the *Journal* in order to have access to it. The online access is complimentary, so you can go to our website and check out the opportunity to link into that. I would encourage you to do that because there are stories about what's happened in accreditation since we launched, and not just from us but stories and case reports from the field. We're especially pleased with some articles that talk about linkages with public health law, the linkage with emergency preparedness, and the crosswalk with *The Community Guide*. There's something in that issue for everybody, and I would strongly encourage you to access that for the work that you're doing.

Melody, let's go to the next slide and get into the weeds with a discussion of 1.5. Ninety percent of the changes in Version 1.5 are editorial. We had not actually expected to issue a new version at this point. We thought it might be a little bit later in the life of PHAB's accreditation, but because of the questions and the comments from health departments in the field, we felt that it was important for us to go ahead and make those changes, which I'll describe those in just a little bit. There are new areas of emphasis, but we're starting those new areas really in baby steps. These are emerging areas in public health. Most of you on the phone would know that these are areas that all health departments are being asked to really look at. Our practice is changing every day, and so we have new areas for emphasis in health



equity, public health ethics, communication science, a few changes in the work force and public health informatics. I'll go over specifically in each of those areas what the changes are.

The new version will be released electronically on our website and through a special edition of our newsletter in January of 2014. It will be effective the first of July 2014. We will have printed hard copies available sometime later in the spring. There is a special edition newsletter that I believe Melody attached to your email that also talks about guidance for health departments to decide which version to use, and I will cover the highlights of those decision points in a little bit. Melody, let's go to the next slide.

Let's first talk about what are those editorial changes, and I'll give you just a summary of those. If you're familiar with Version 1.0, the number of examples and the requirements for the dates, whether it was annually or biennially or every three years, or whatever the requirements were included in the guidance in Version 1.0. In the Version 1.5, we have created columns by each measure, so there is no guessing or looking through narrative for how many of the examples do we need for the measures and in what time frame. That is strictly a format change. There is no change to the requirements, just a format change to help applicants to find that information more clearly.

There are a number of editorial changes that were suggested to us that we made that created rewording to improve clarity. We removed some of the word "should" and replaced it with "must" or either deleted it altogether if it was confusing, and we removed "such" as "for examples include," so I won't go over all of those, but there are a number of those kinds of things. There are also a number of places where, based on the questions that we have tracked from applicants or potential applicants, we have added explanatory language to the documentation guidance just based on the questions that we have routinely received.

We've also added some more description of examples in the list of examples just based on our experience thus far. There will be a new glossary that will be attached to Version 1.5, and so we will add some new definitions based on questions we've gotten. "Healthcare-associated" in sections, "primary data," "closer evaluations," some of those kind of things. We've reconsidered the use of "and," "or," and "and/or" throughout the document to ensure appropriateness. Sometimes when we were trying to be flexible it was actually more confusing. We also updated information from the guide to documentation where there was specific reference to the Standards and Measures so you can look in one place if you're looking for Standards and Measures. Of course, as always, there were a few typos and we've corrected those. That's it so far as editorial changes, and that is primarily what has happened in Version 1.5.

Melody, let's go to the next slide, and we'll talk about those new areas. As I mentioned, one of our new areas, because it is an emerging topic that we're all discussing in public health practice, is around health equity. But what our committee learned and what we learned through the vetting is sometimes the use of the phrase "health equity" is challenging. While it's appropriate to describe what we're trying to accomplish, it may be politically difficult to use in certain jurisdictions. Our committee and our board agreed we're using the phrase "specific populations with higher health risk or poorer health outcomes"



throughout the documentation, and we've added it in places where it would be strategic and logical rather than to create a whole section. For example, where we talk about demographic data, contributing causes, or in the community health assessment (CHA) and community health improvement plan (CHIP), we've talked about socioeconomic factors, racial ethnic factors, sexual orientation, and so on and so forth, we've tried to be really careful, but we do know that many health departments are working on an inclusion of "health equity" language anyway.

We added a new measure to Standard 3.1, that's health education and health promotion, to require efforts to specifically address factors that contribute to specific populations' higher health risk and poorer health outcomes, to make sure. There's not much point to do a CHA and CHIP without addressing specific populations that might have higher health risk, and most health departments, we find, are doing that already anyway, so we certainly needed to call that out as important. We've included additional examples of non-traditional partners in those partnerships that specifically address public health issues or populations with particular higher risk for those socioeconomic factors that affect health, and that would be partners like housing, transportation, education, and including representatives of the communities impacted. But those are just additional examples.

We think we've better defined community assets and resources to be included in the CHIP, and we've added language that CHIP policy changes must address those that are adopted to alleviate the identified causes of health inequity. Again, this is aimed at policy changes that address social and economic conditions and those that include housing. It's the "multiple determinants of health" language and that's under health equity. Mostly what we've done is put an emphasis on the inclusion of health equity work and work that the health department is already preparing for accreditation. The only new measure is Standard 3.1, which talks about specifically addressing factors that contribute to specific populations' higher health risk and poorer health outcome. That ends health equity.

Public health communications science. Most of these changes are in Domain 3, of course, because that's where health communications and health promotion occurs. We have emphasized cultural competence in health promotion in the guidance. We've added required documentation for a planned approach for developing and implementing health promotion strategies. In the documentation items we've stressed a need to engage the community in the development of health promotion programs. That's strictly based on public health education communication science that if you're providing health education and health promotion information to a community, it's nice to be able to test those messages with representatives of that community or that target population before they're implemented.

We've included examples of the use of various types of media because many health departments asked us to speak to the use of digital media social marketing, and we've included it as a method to inform partner organizations about the availability of the community health assessment and we've provided examples. We've also enhanced the required documentation explanation for describing the relationship with the media and the use of diverse media outlets, and those may be urban radio stations, free community newspapers, migrant worker newspapers, those kinds of things.



The only new measure in this section is a new measure, Standard 3.2, which requires that the health department have a branding strategy. This has been a promising practice, and now a best practice, in public health for quite some time, and PHAB delayed the addition of this standard until this time just because the whole notion of accreditation was so new, and a lot of the branding work was just started. But most health departments now do have a branding strategy, and so it's prudent for PHAB to begin to include that in our Standards and Measures. We also, based on feedback from the field, removed the requirement for the technology TTY because it's out of date and there are other modes of assistive technology for the health departments to use. And that ends communication science.

I hope you can see from the first two examples that I've described in some detail that again, most of what we're doing is updating language, adding examples, and only so far have we discussed the addition of two new measures.

We move now to public health informatics. This is such an emerging field for health departments. We wanted to be sure that we keep up with what's going on in the field, but we don't get too far ahead of health departments' ability to be able to address all the new and emerging items in informatics. What we've done here is included electronic data as an example of processes and protocols to the collection review and analysis of comprehensive surveillance data. We have added to required documentation the requirement of analysis of data that demonstrates the use of data from multiple sources, not just one source.

We have a new measure in Standard 1.2 to require the collection of primary quantitative and qualitative data, and the explanation that we've added is that doesn't have to be complicated, but it augments the typical quantitative data that health departments have to include, things like a simple survey of tenth graders for smoking cessation purposes, for example, or a summary of the information that health departments might have gathered on a particular topic from a focus group. We're not talking about research here, we're just talking about the additional collection of data.

We revised Measure 11.1.6 to require that the information management function in a health department support the health department's mission and workforce by providing infrastructure for data storage, protection, management, data analysis, and reporting. You may recall that what we have had so far is a list of the hardware and software, and we certainly realized we needed to move beyond that.

Public health workforce development. The primary change here is that the human resource workforce development measures from Domain 11, administrative and management, were moved to Domain 8 so that all the materials related to public health workforce are found in one location. Because of that, the requirements for the workforce development plan are much more streamlined. Rather than have them in separate measures, we've included them as elements in a workforce development plan. Much like the strategic plan has required elements, we've streamlined the workforce development plan. The new measure here is a measure that we overlooked the first time, and that is the measure that addresses the health department as a work environment for the public health workforce and what the health department does in order to support its workforce, whether it's the provision of a wellness program,



flex time, a breastfeeding room for breastfeeding mothers. There's a whole array of things that health departments are doing, but it's very difficult to think about supporting a workforce without thinking about the health department as a good place to work. We're almost done with these two. We've got two more categories here.

Emergency preparedness. We added a concept of community resilience in several places because that's terminology now being used in emergency preparedness. We better defined "cluster evaluation" and "disaster treatment." "Disaster" now includes natural, man-made, and terrorism. In the emergency operations plan, we added the requirement to address the entire population, including special needs of a vulnerable population, but no new measures in that arena.

Public health ethics. We have a new measure in Domain 11 that requires strategies for decision-making relative to ethical issues and for documenting accordingly. This shouldn't be complicated for a health department. All health departments at one time or another are confronted with issues that are ethical in nature and ethical conflicts that have to be resolved, and so all we're saying here is health departments need to describe for us what their practice is, what their process is when those kinds of issues arise, and we ask for an example or two associated with that. That ends the special topics.

If you wonder why there's not a topic related to health reform, we got lots of comments during the vetting period that PHAB needs to be aware that health departments across the country are dealing with all kinds of changes related to their relationship with the healthcare system, with healthcare reimbursement, with ACOs, etc., and we know that, but what we also know is the practices are all over the place and they're very much in flux right now. They're ever-changing, and so PHAB will look at Domain 7 particularly over this next year in light of what is going on with health reform and make the appropriate changes when we have good evidence that will guide us to do that.

There are probably eight or ten other minor changes that really don't increase the requirements for health departments, but rather clarify. One example that I will give you here is that we had a requirement in the Domain 11 that there be an Americans with Disabilities Act (ADA) audit, and we know that that only occurs when there's significant renovation or a new building's built. It never occurs if the building is a historical building. We replaced it to better reflect what we intended to get at with the ADA audit, and that is assurance of accessibility to the health department's facilities for persons with disabilities. We've added some specific language around clarification of the timing of the CHIP and the monitoring and refreshing of that just based on the questions from the field. Those are the general other changes that are included in Version 1.5. Next slide, Melody, and then we'll wrap this up and open for questions.

Melody Parker: Okay. I actually do have a question for you that kind of relates to what you're talking about now. Can I throw that at you?

Kaye Bender: Okay, if you want to do that now, that's fine.



Melody Parker: It's from Robert Heinz, and he asks if behavioral and mental health will be addressed in the new version, and will documentation from these areas be accepted now considering the increased focus on higher health risk, which is closely related to behavioral health?

Kaye Bender: Robert, that's a great question, and it's one that we get all the time. We have not specifically added behavioral and mental health in Version 1.5 for two reasons. One is, depending on whether it's individual or group, there is another accrediting body that accredits or oversees that aspect of behavioral and mental health. That rationale is the same rationale that we use for why we don't accredit the side of health departments that have primary care clinics because there is another accrediting body for that.

The second reason is that not all health departments have responsibility for behavioral and mental health, and so we're still trying to figure out exactly what we should do going forward. Since 1.5 was not a wholesale change in the Standards and Measures we didn't include those. Having said that, whether it is health promotion or whether it's in your CHIP or whether it's communications or some of your programmatic examples, for example, those that are related to chronic disease, they're certainly population focused, behavioral interventions there. And those kinds of examples you can use. But traditional individually focused, behavioral or mental health services we do not include because there's another body that accredits those. We'd welcome any suggestions you have for future versions of the Standards and Measures and how we might better accommodate those requests. We do get that question a lot. Is that the only question, Melody?

Melody Parker: Yes, for now. Go right ahead, Kaye.

Kaye Bender: We'll wrap up this segment, and then I'd love to hear some more questions or comments from you. The health department's been working on accreditation, and we're sort of at that decision point of whether we want to apply under Version 1.0 or wait and apply under Version 1.5. Certainly that's the decision of the health department, and there are some guiding principles that are in that newsletter that Melody attached to your email that I just want to touch on.

If your health department is fairly well-read and you've been working on Version 1.0 and you want to go ahead and apply because you want to be accredited under Version 1.0, that application must be submitted by midnight on June the 2nd to be assessed under Version 1.0. The reason that it's June the 2nd and not June the 30th is that we have to have sufficient time to review the application and have the health department correct any errors noted by the PHAB staff, then process the final review and acceptance of the application prior to July the 1st. Fifty-three percent of our applications have required a change in the application after PHAB staff review, and so it's based on that experience that we have built in that 28-day review time. If you submit your application on June 3rd or after, we will assume that you intended and knew that we would be using Version 1.5. We also strongly recommend that if you pretty much know that you are going to apply under Standards and Measures Version 1.0, go ahead and submit your statement of intent. It isn't that long until June the 2nd, and if you go ahead and do that



then we can work with you to have access earlier to the application form, and we can work with you on the planning for making sure that that review occurs in a timely manner.

We also recommend that before you actually decide, that you might want to look at Version 1.5 when it's posted in mid-January because many health departments who actually reviewed 1.5 during the vetting process said, "Oh, we're going to wait because Version 1.5 was more clear, and we think that we will be able to work with that version a little more readily than Version 1.0." So, if you're on the fence, then we would suggest that right after it's posted in January you take a real strong look at it and make that decision. If you still have questions after that, you can contact any one of us here at PHAB and we're happy to help walk you through some items to think about. PHAB will also be hosting two additional webinars on the changes and implications for application in the spring, and you would certainly be welcome to join us for that.

Lastly, I would just note that PHAB does not intend to continue changing the Standards and Measures this quickly. Like I said at the beginning, we didn't anticipate making these changes this soon. We did so largely in response to requests from the field, but I don't want you to worry that if you start working on 1.5, that before you're finished with that there will be another version that you have to contend with. We're going to leave the Standards and Measures stable for a little while, with the only possible exception being what I said about health reform. If there are significant reasons that we need to go ahead and address those emerging areas, then we may do that sooner than we would revamp the whole set. Or if something emerges in public health that is just absolutely so necessary, then we will leave that possibility open. But it is our intention to leave those Standards and Measures stable for a little while. That concludes my comments, Melody, and I'm currently open for questions or feedback or any discussion that the group might wish to have.

Melody Parker: Thank you, Kaye. As always, time spent with you is enlightening and thoroughly entertaining. The last time I heard you speak was at the Town Hall at the public health improvement open forum in Memphis. Was that just last month? Really, this is just an opportunity to address Kaye and PHAB in general with just about any question you may have about accreditation. She's open to addressing even rumors, possibly, that you've heard as far as anything about accreditation and obtaining accreditation goes. This is your chance to ask her just about anything that has crossed your mind or your plate about accreditation. The lines, I believe, are now open, and you are welcome to ask your questions.

Operator: All lines will be open for the duration of today's conference. If you would like to mute your line, you may press star-6.

Colleen: Hi. We have a question. We are calling from the New Mexico Department of Health.

Melody Parker: Yes, go ahead.

Kaye Bender: Hi, Colleen.



Colleen: Hi. We have actually been getting some good feedback from what we call our domain champions, so they're the ones that are gathering the documentation, working with the measure leads to get the best documentation that reflects our department. We had a question not too long ago. I know that we attended the training in Alexandria, and you all had some contractors. And they followed up and asked us questions regarding the training. Our champions were interested to see if PHAB was going to be doing a follow-up with departments regarding any concerns that they had along the way, or you know, experiences. Is PHAB going to be doing that, or are they doing that for departments that have been accredited already?

Kaye Bender: Yes. That's a bright question, Colleen, thank you for asking it. We are trying to walk the talk that we ask health departments to do, and that is we have a number of initiatives that we put in place around our own quality improvement. One of those buckets, if you will, is a series of evaluations for our trainings where we ask the participants to let us know. You know, then we ask specific questions about improvements, and we go ahead and use those. We do the same thing related to our site visitors, experiences with each other, and also their experiences as site visitor. That's one bucket of getting feedback.

In addition to that, we have a contract with the National Opinion Research Center at the University of Chicago, and they are conducting our external evaluation. Once a health department's been accredited then they have a series of questions that they will ask those health departments about how things went, what suggestions they would have for improving the process, that sort of thing. Then starting in early 2014, they will also survey or sample a few health departments who are in our system but who seem to be taking longer. They're still within the time frame, but they're taking longer than the average health department, if you will. They will be checking with those health departments to see if there's something about a process that is confusing or something that we could assist the health departments, not to rush them, but to make sure that they don't run out of time with their deadlines.

Then lastly, for the accredited health departments' annual report, there's also a lot of feedback that we'll be asking the health department about the so-what of accreditation including the impact of accreditation on their health department, just going through the process and what they've been able to sustain once they got their plaque and their letter. I hope that answered your question, but we do have a number of places where accredited health departments are surveyed, as well as site visitors are surveyed so that we're constantly asking about the process and what we could do to improve.

Colleen: Okay. Well, thank you so much, Kaye, and happy holidays.

Kaye Bender: You, too, Colleen. Thank you for the question.

Melody Parker: All right. The lines, of course, are still open, so, of course, seize the day, y'all. Get in there.

Kaye Bender: While we're waiting for people to be brave, Melody, I might also mention that at the Town Hall, we learned that there'd been a rumor out that our fees were going up with Version 1.5. We



thought that was an interesting rumor because it's not going to cost us any more to manage 1.5. It will be a challenge because we'll be managing two versions at the same time. As we always do, we'll announce the fee schedule for 2015. We announced 2014's fee schedule last year, and there is no change. Thanks to the generosity of the Robert Wood Johnson Foundation and the Centers for Disease Control, who support a lot of our developmental infrastructure and our evaluation and that sort of thing, we don't have pass those costs along to the applicants, and so we are fortunately able to keep the fee the same as it has been, and so we'll continue with that.

Melody Parker: Call it a holiday gift.

Unknown: Hi. You had mentioned that there were categories of applicants, like you had mentioned the centralized state and the multi-jurisdictional state, so how does that apply to people who are already in the application process, because that was the first that we heard that?

Kaye Bender: Well, if you're already in the application process, then you've already decided what your application category is. When we launched the program, we had already had the request and had developed the category of multi-jurisdictional. Largely, that was developed because, as you know, one of the hot topics in public health right now is for small, rural health departments or maybe a larger health department with several small health departments around it, the sharing of services.

A local health department can apply as a local health department and document its partnerships, and that's fine. But there was a request for us to develop an application category where a health department who has a track record of not merging, not regionalizing, but working together already, so one health department in a multi-jurisdiction of three health departments, three county health departments, maybe one health department is stronger and provides the epi and surveillance for those three, and another health department maybe provides the emergency preparedness piece, but they all work together. We had the request to have an application category where they could apply all together. That category's been there since September of 2011 when we launched, but we've received our first application in that category.

With centralized states, those are states where the state health department operates some or all of its local health departments. Those local health departments can apply as a local health department with permission of their state health commissioner, but we also had the request that we create categories where they could apply as a district within the state, if that's how they work, or as the state as a whole, all of the local health departments together. Those categories have been there since September 2011, but we've just now gotten our first applications in those areas as well. Did that answer your question?

Unknown: It did. This is New Mexico again, and our situation's a little bit unique in that we're a centralized state with no local health departments at all.

Kaye Bender: Yes, thank you. If you're a centralized state with no local health departments, then you would apply as a state health department.



Unknown: Okay, perfect. That answers our question.

Melody Parker: All right. We are coming up towards the end of the hour. You still have a few minutes if you'd like to get in a question on the lines, or even on the Q&A in LiveMeeting.

Lisa Aquino: Hi. This is Lisa Aquino from Alaska, and I have a follow-up question to New Mexico's question. You know, we also are a centralized state with really no local health departments, but we have all of our tribal system here and I think, Kaye, you know Alaska pretty well. I'm just wondering about multi-jurisdictional, that would be tribal and state applying together too, right?

Kaye Bender: It could be. It could be, and I know that I've been so proud of you guys for working together as you've worked on quality improvement, performance management, accreditation. Having been there and observed that, I think you guys are well on the right track. We can talk to you more specifically offline. You could apply as multi-jurisdictional, but we didn't see the benefit to you guys doing that. We thought that you could apply the health department as the state health department, and the consortium as one entity, you know, all together. Where you're sharing your documentation and whatever, that could just simply be noted. But the real thing is, and I want to use this as a great example. I'm glad you asked the question, because this is true for anybody that's on the call. This is a situation where when you get a little closer and ready to actually make the application decision as to which way you want to go, it would be very good, I think, if we scheduled a conference call with you guys and also with the consortium representatives, and let's talk through which way works the best for you. We will accommodate whatever you want to do, but there are pros and cons, obviously, to both ways, and so we really do like to have that conversation with you before you make that final decision. We're happy to set that up whenever you're ready.

Lisa Aquino: That's terrific. Thank you so much.

Kaye Bender: Thank you. Keep up that good work.

Melody Parker: All right. Well, it appears that we may have exhausted our questions, at least the ones that will be asked in this particular venue. I'd like to thank everyone for their participation on the call today, especially the good Dr. Bender, who is wonderful to take time with us, and thank you so much for giving us the very first discussion preview of the Version 1.5 Standards and Measures, Dr. Bender. Before we leave today, just one quick feedback poll. How would you rate the webinar over all, excellent, good, fair, or poor? In the meantime, if you'd like to give us any additional feedback on the call, if you have any other questions for Dr. Bender, or suggest even future topics for calls to come, please email us at PIMNetwork@CDC.gov.

Harald: Hey, Melody?

Melody Parker: Yes, is that Harold?

Harald: Hi. Yes, this is Harold. Dr. Bender, just a quick question. I know with the very large amount of people who are currently in e-PHAB, are you seeing that it will all be done in a timely basis, or are you



having a metric on how long it will take to get a health department accredited from the time they enter to the time that their application is completed?

Kaye Bender: Hey, Harald. That's a great question, and we get asked a version of that question a lot because we do have 248 in the system and 22 accredited. We are analyzing, as I mentioned, I don't know if you were on the call when I mentioned that one of our buckets within ORC is to have them talk to some of the health departments that are taking longer on their end to see what we could do to help them make sure they don't miss their deadlines. So far, the rate limiting factor has been the health department, and in a few cases getting the site visit scheduled between the health department director's schedule and the site visitor's schedule. Those are the two factors.

At this point we've experienced no delays as far as PHAB's internal work, but we do have to remember that the reviewers are volunteers, so sometimes that does pose a little bit of a delay. What we are seeing, interestingly enough, is the trend that some of the applicants that have applied later are moving through faster, more efficiently or whatever you want to call it, than some of the earlier applicants. The only thing that we can surmise is in the first year or so after the launch of the program, maybe some health departments applied thinking they were more ready than they were, and then after they came to the training they learned a good bit about their documentation, and they needed to go back and do some shoring up. But we have, in this next batch of health departments that have just recently been site visited or are about to be, they're some of our more recent applicants. So internally and within ORC we're looking at those factors that affect the progression of a health department through the system to try to figure out how we can work with health departments to move those along.

Harald: Thank you.

Kaye Bender: Thanks for asking that question. It's a good one.

Melody Parker: Indeed. Again, thank you to Dr. Bender. Please join us for our next call. That will be scheduled for January 23rd. Of course, in the meantime, remember that you can view and download these calls and all accompanying materials from the PIM Network webinar series on the OSTLTS PIM Network website. With that, I wish you all a fervent season's greetings. I hope that you get all the rest you need during any leave time you may have, and we will see you in 2014.

Kaye Bender: Happy holidays, guys.

Melody Parker: Thanks, Kaye.

Kaye Bender: Bye-bye.

Melody Parker: Bye-bye.

Operator: This concludes today's conference. Thank you for your attendance. You may disconnect at this time.

