Standards & Measures for **Initial Accreditation**

Version 2022

PHAB

Adopted February 2022

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INTRODUCTION

This Public Health Accreditation Board (PHAB) **Standards & Measures for Initial Accreditation, Version 2022** document serves as the official standards, measures, required documentation, and guidance blueprint for PHAB national public health department initial accreditation. In addition, the requirements that apply to all documents submitted to PHAB are included in this document. These written guidelines are considered authoritative and are in effect for applications submitted on or after July 1, 2022 and until a new version is released.

In general, "**The Standards**" referenced in this document collectively refer to this entire document including the introductory material, domains, standards, measures, required documentation, and guidance.

The Standards provide requirements and guidance for public health departments preparing for initial accreditation and for site visit teams that review and assess documentation submitted by applicant health departments. It also serves anyone offering consultation or technical assistance to health departments preparing for accreditation. It guides PHAB's Board of Directors and staff as they administer the accreditation program.

Credibility in accreditation results from consistent interpretation and application of defined standards and measures. **The Standards** set forth the domains, standards, measures, and required documentation adopted by the PHAB Board of Directors in February 2022. The document also provides guidance on the meaning and purpose of the measures and the types and forms of documentation that are acceptable to demonstrate conformity with each measure.

The Standards provide assistance to health departments as they work to select the best evidence to serve as documentation. Health departments should submit all questions related to any part of The Standards, including documentation and measure requirements, to PHAB.

GUIDING FRAMEWORKS

Domains are groups of standards that pertain to a broad group of public health services. There are 10 domains, aligned with the 10 Essential Public Health Services framework.

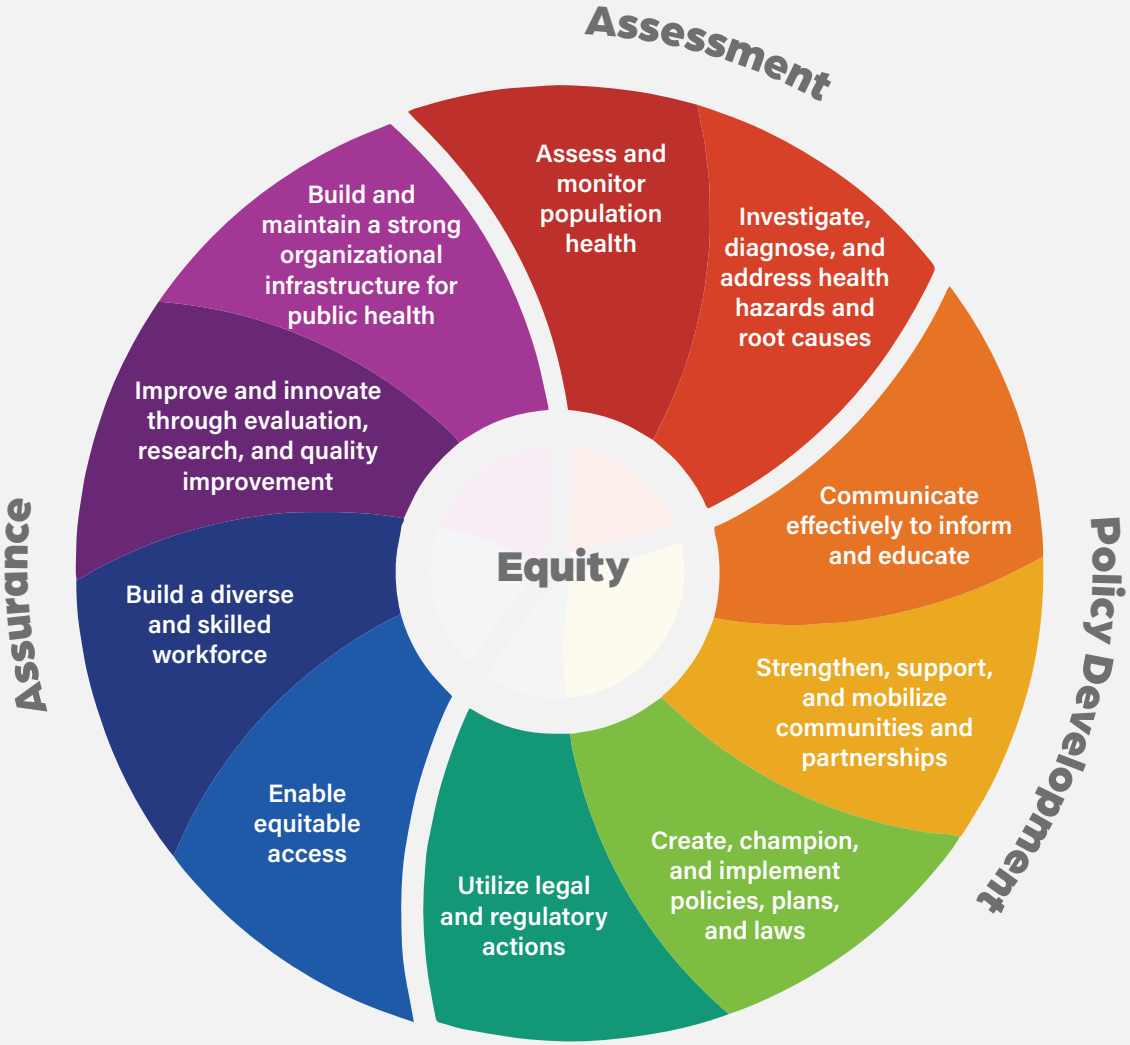
Standards describe the level of achievement expected of a health department. Measures describe the specific requirements needed to meet those expectations. Required documentation is the documentation that is necessary to demonstrate that a health department performs functions that conform to a measure.

All of the standards are the same for Tribal, state, and local health departments. The majority of the measures are the same for Tribal, state, and local health departments and these are designated with an "A" for "all." Where the measure is specific to Tribal, state, or local health departments, it is designated with a "T" for Tribal health departments, "S" for state health departments, and "L" for local health departments. Some measures are designated T/S (as applicable to Tribal and state health departments) and some are T/L (as applicable to Tribal and local health departments).

The structural framework for the PHAB domains, standards, and measures uses the following taxonomy:	
Domain	Example – Domain 1
Standard	Example – Standard 1.2
Measure	Example – Measure 1.2.2
Tribal, State, Local or ALL	Example – Measure 1.2.2 S for state health departments; Measure 1.2.2 T/L for Tribal and local health departments; and Measure 1.2.1 A for all health departments

10 Essential Public Health Services

PHAB's public health department accreditation domains are aligned to the 10 Essential Public Health Services (EPHS) framework. Equity is at the center of the 10 Essential Public Health Services to actively promote policies, systems, and overall community conditions that enable optimal health for all. Public health department accreditation standards address a range of core public health programs and activities including, for example, environmental public health, health education, health promotion, community health, chronic disease prevention and infectious disease, injury prevention, maternal and child health, public health emergency preparedness, access to clinical services, public health laboratory services, vital records and health statistics, management/administration, and governance. Thus, public health department accreditation gives reasonable assurance of the range of public health services that a health department should provide.



Foundational Public Health Services

The Foundational Public Health Services (FPHS) framework defines a minimum set of capabilities and areas that must be available in every community and outlines the unique responsibilities of governmental public health. The framework is comprised of eight (8) public health infrastructure foundational capabilities and five (5) public health programs, or foundational areas. Foundational Capabilities are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being and achieving equitable outcomes.

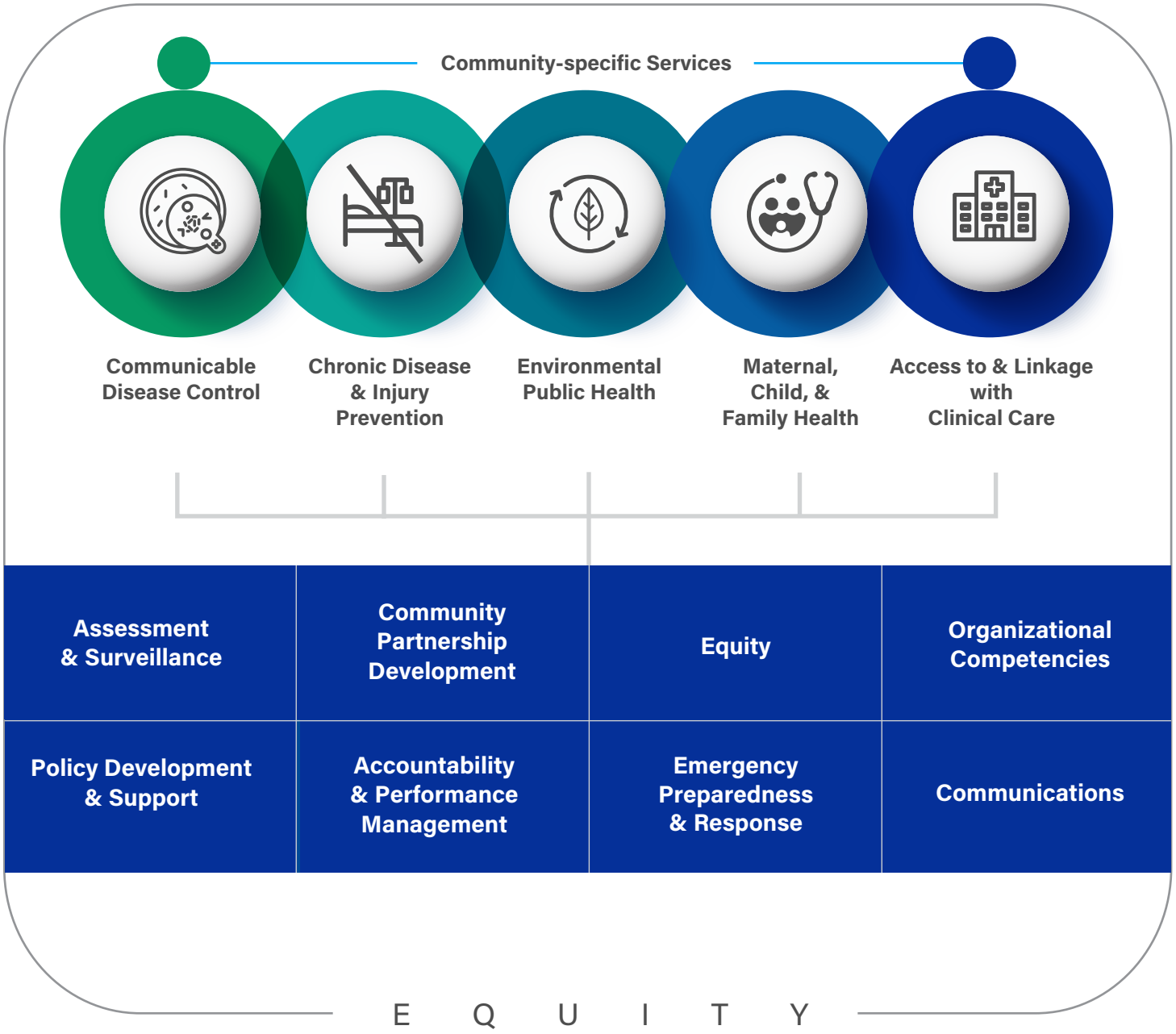
Foundational Capabilities, which provide the infrastructure needed to protect and provide fair and just opportunities for all, include: 1) Assessment & Surveillance, 2) Community Partnership Development, 3) Equity, 4) Organizational Competencies, 5) Policy Development & Support, 6) Accountability & Performance Management, 7) Emergency Preparedness & Response, and 8) Communications.

Foundational Areas are basic public health, topic-specific programs and services aimed at improving the health of the community affected by certain diseases or public health threats, which include, but are not limited to, chronic disease and injury prevention; communicable disease control; environmental public health; maternal, child, and family health; and access to and linkage with clinical care. These areas reflect the minimum level of service that should be available in all communities.

To promote accountability, **The Standards** designate which measures correspond to the foundational capabilities in the FPHS framework. Although equity is called out as a specific Foundational Capability, it is also recognized as a component of all the work of a health department. Similarly, although only a few measures in The Standards are designated as being aligned with the Equity Foundational Capability, many more of the Foundational Capabilities Measures address how health departments infuse equity throughout their work. To achieve and maintain accreditation status, health departments will need to demonstrate conformity with these Foundational Capability Measures or complete additional reporting to show their progress towards demonstrating them.

Foundational Public Health Services

Foundational Areas



Foundational Capabilities

Assessment & Surveillance	Community Partnership Development	Equity	Organizational Competencies
Policy Development & Support	Accountability & Performance Management	Emergency Preparedness & Response	Communications

E Q U I T Y

PHAB

STRUCTURE OF THE REQUIREMENTS

Each domain begins with a description of the domain, followed by the standards and measures. The chart below provides an example of the layout for standards, measures, required documentation, guidance, number of examples, and timeframe for required documentation.

STANDARD 1.1

This is the standard to which the measure applies.

Purpose & Significance

This section describes the public health capacity or activity on which the health department is being assessed. This section describes the necessity for the capacity or activity that is being assessed.

MEASURE

This section states the measure on which the health department is being evaluated.

FOUNDATIONAL CAPABILITY MEASURE

When a measure is designated as a "Foundational Capability Measure" it will be indicated in this section.

MEASURE 1.1.1 A: **Required Documentation #**	**Guidance**	**Number of Examples**	**Dated Within**
This section lists the documentation that the health department must provide as evidence that it is in conformity with the measure. All elements must be included to fully demonstrate the measure. The documentation will be numbered: 1. Xxx 2. Xxx a) xxx b) xxx	This section provides guidance specific to the required documentation. The guidance is intended to help a health department think about the intent of the requirement and what they could provide to meet the required documentation. Types of materials may be described (e.g., meeting minutes, partnership member list, etc.). Examples that illustrate the types of documentation may also be provided here and are intended to help health departments consider what might be appropriate. The health department does **not** need to submit documentation that aligns with these examples.	This section states the number of examples required. It will also specify what type of documentation to provide, whether it is an example, policy, plan, or other type of document.	This section states the time frame for the date on the documentation.

REQUIREMENTS FOR ALL DOCUMENTATION

All documents submitted to PHAB must comply with the following. Documents submitted to PHAB that do not follow one or more of the bullets below will **not** be assessed as Fully Demonstrating the measure.

- Documentation must directly address the measure, with particular attention to the elements listed in the "Required Documentation" column. When selecting documentation, the health department should carefully consider the context in which the measure is located (i.e., the standard and domain).
- All documents must include a Documentation Form, completed in accordance with the "Documentation Form" section below.
- All documents must include a date and be within the timeframe indicated in the "Dated Within" column (see "Timeframes" section).
- If the "Number of Examples" column calls for anything other than an "example," (in other words, if the "Number of Examples" column says, "plan" or "policy") that document must be the current version in use by the health department at the time of the submission of documentation to PHAB. For example, the health department must provide the most recent workforce development plan or investigation protocol.
- Health departments cannot provide examples from program areas that were no longer part of the health department at the date of documentation submission. For example, if a health department no longer has an oral health program, then no examples from that program should be submitted. Health departments can provide examples of specific projects (e.g., a social media campaign, an evidence-based intervention, or projects related to grant deliverables) that have been completed, so long as the overarching program area is still part of the health department.
- All documents must show evidence of authenticity to demonstrate the document's relevancy to the health department (see "Authorship and Evidence of Authenticity" section).
- Health departments must follow PHAB instructions for requirements to be assessed as "Not Applicable" (see "Requirements that are Not Applicable" section).
- No draft documents will be accepted for review by PHAB, with the following exceptions: (1) packaging a draft document with final version to demonstrate changes made, or (2) packaging a draft document with additional documents that demonstrate a health department's efforts to propose changes if the "Guidance" column indicates that unsuccessful or not yet completed efforts are acceptable.
- Documents must not contain blank signature lines, as this indicates a draft document. If a document includes a blank signature line and the health department is not able to either provide a signed copy or obtain a signature, the health department director may provide a signed memo with the document explaining why the signature line is blank and attesting the document provided is not a draft document.
- Examples must be within the scope of PHAB's accreditation authority to assess (see "Scope of Authority" section below).
- Documents must be submitted to PHAB electronically, as a PDF file. Other acceptable file formats include audio and video files. Hard copies of documents must be scanned into an electronic format for submission. PHAB will not accept hard copies of any documentation at any point in the process.

- All written documents must be readable and open correctly (e.g., scanned text must be legible and open right-side up). All audio and video files must open correctly.

In addition:

- As part of the terms of conditions, health departments agree that all information submitted to PHAB, including explanations in the Documentation Form, are truthful and accurately reflect the functions performed by the health department, including its mandates and legal requirements.
- At all times, health departments are solely responsible for abiding by all applicable state and federal laws regarding personal or sensitive information. For example, for requirements related to personnel, state or federal law may require the health department to redact the names of employees. In addition, state or federal laws may prohibit disclosing personal health information to PHAB (including through e-PHAB).
- If multiple documents are used to demonstrate an example, they must be packaged together to create one PDF per upload. Additional resources, such as guidance health departments can use to create PDF documentation, are located on PHAB's website (www.phaboard.org).

Selection of Documentation

The health department should select documentation carefully to ensure that it accurately reflects the health department, how it operates, what it provides, and its performance. To ensure the Site Visit Report, as prepared by the Site Visit Team, is an accurate reflection of the health department, the health department should select documentation that reflects the array of programs, services, and functions it performs while choosing the most relevant and accurate documentation to submit to PHAB. Documentation is expected to include programs that address causes of public health issues, determinants of health, and chronic disease and must address the health of the population in the jurisdiction that the health department has authority to serve.

Health departments are encouraged to consider how the selected documentation articulates how the health department performs functions or activities. For example, health departments might organize files in chronological order or sequence of events or actions. Health departments are also encouraged to consider how the compilation of the documentation submitted to PHAB tells the story of how the health department operates and how it serves its communities.

Documentation submitted to demonstrate conformity with a measure does **not** have to be originally from a single document; several documents (combined into one PDF file) may support conformity for each item listed in the "Number of Examples" column (e.g., each example, policy, or plan). Documentation Forms may be used to summarize or provide an explanation of how the documents, together, demonstrate conformity with the measure. The specific section(s) of the documents that addresses the measure must be identified.

The health department should not upload more documentation than is required to demonstrate conformity with the measure. That is, if two examples are required, the health department should not upload more than two examples unless requested by PHAB or the Site Visit Team. Additional examples, unless requested by the Site Visit Team, will not be reviewed and the measure may be reopened for clarification.

Documentation Forms

For each item listed in the "Number of Examples" column, a Documentation Form must be completed and submitted with the documentation (e.g., if the "Required Documentation" column requires two examples, two Documentation Forms will be provided). This applies to documentation provided during the documentation submission step, any measure reopened by the Site Visit Team, and any ACARs. Health departments must use the Documentation Form that corresponds with each requirement. The Documentation Forms may be accessed from PHAB's website.

The use of the Documentation Form ensures that the Site Visit Team can easily identify evidence corresponding to the requirements. The Documentation Form should specify the specific part or section of document that addresses each required element in the measure, by referencing the **PDF page number** of the relevant part of the document. (The page number should represent which page in the PDF document; in other words, if the health department compiles excerpts from several different documents, the page number will indicate that it is the 5th page in the PDF, regardless of the page number on the original excerpt that has been merged into the PDF.)

Some measures in **The Standards** indicate in the "Required Documentation" column that required elements may be provided on the Documentation Form itself. For these requirements only, the Documentation Form may serve as the health department's evidence for the specific required element noted in **The Standards**. The health department maintains the option to include the evidence as part of the documentation or provide evidence in the Documentation Form. In all instances, the health department may use the Documentation Form to provide supplemental information or context to help the reviewers understand how the documentation relates to the requirements. Similar to how the "Guidance" column provides examples of documentation the health department could consider providing, the "Guidance" column also includes examples of how the Documentation Form may be used to supplement documentation with contextual information.

The Documentation Form must be merged with the documentation into one PDF per example. That is, if two examples are required, there should be only two uploads. Each upload will be a PDF that includes the completed Documentation Form and documentation that addresses all elements in the "Required Documentation" column.

Timeframes

All documentation used to demonstrate conformity with measures must be **dated** within the timeframe indicated in the "Dated Within" column. The date indicates when the document was created, adopted, reviewed, or revised. **The Site Visit Team will look for the date on the document.** Dating of all documents is a best practice to ensure the health department is aware of when information was last updated. Dates on documents also enable the PHAB Site Visit Team to understand if the documentation is within the required timeframe, when assessing conformity.

The specificity of the date on the document will depend on the documentation requirement and the type of document. For example, emails provide the full date and time. Policies may include the month, day, and year. Reports may include the month and year. A brochure may include only the year. Audio and video files will either include the date within the content of the file or the Documentation Form will be used to clarify the date.

Timeframes are determined by **starting from the date of submission of the documentation to PHAB.** If the timeframe for a plan is five years, the plan must be dated within the five years prior to the health department's official submission of documentation to PHAB. For example, if the health department submits its documentation on January 1, 2023, any documentation that says "5 years" within the "Dated Within" column must be dated on or after January 1, 2018.

Authorship and Evidence of Authenticity

The focus of **The Standards** is that the health department ensures that the services and activities are provided to the population, regardless of who provides the services and activities. The accountability for meeting the measures rests with the health department being reviewed for accreditation. Unless **The Standards** indicate that required documentation is not applicable to a particular health department, documentation must

be provided to demonstrate evidence of meeting the measure, even if the documentation is produced by another entity.

All documents must show evidence of authenticity. That is, the document must have a logo, signature, email address, or other evidence to demonstrate authorship or adoption.

For documentation developed or adopted by the health department, evidence of the health department name, logo, signature, email address, or other evidence that links the document to the health department will be included on the document. For example, a policy could include the name of the health department or county government logo, an email could include names on the "To" and "From" lines or a signature block that provides clear evidence the person is an employee of the health department, or a community health assessment may include the CHA partnership name with a participant list. If the evidence of authorship may not be clear to someone outside the health department, the Documentation Form may be used to clarify (e.g., if the email "To" or "From" lists only the name of the individual).

If the documentation was developed by another entity (e.g., partner, governmental agency, contractor) the health department must demonstrate the document's relevancy to the health department (e.g., how the health department contributed or uses the documentation, or how it's relevant to the health department's jurisdiction). If the health department did not develop the materials, **The Standards** may indicate that formal agreements are required. If a particular required documentation does not specify that a formal agreement is needed, the Documentation Form may be used to indicate how the documents are relevant or used by the health department.

Examples include:

- **Health departments may have formal agreements or partnerships with other organizations to provide particular functions or activities.** If the Measure requires the health department to demonstrate that it has the capacity to provide a particular service, (e.g., Measure 3.1.1's requirement for the capacity to communicate with non-English speaking individuals) and the health department relies on another entity to provide that service, the "Required Documentation" column may indicate that a formal agreement (e.g., a Memorandum of Understanding (MOU), a contract, or other written agreement) is needed. If, however, a measure requires an example of a product (e.g., a report, evaluation, data analysis), the health department may submit a documentation developed by another entity, as long as the documentation meets all of the requirements in the measure and is relevant to the health department and the population it serves. Examples of acceptable documentation include: an evaluation developed by a consultant of a program that the health department operates; or a data analysis conducted by an academic institution about the population served by the health department.
- **Health departments that operate as agencies within a larger governmental unit, may utilize the policies, procedures, or functions of that larger governmental unit.** For example, a health department may utilize the human resources system of the government of which it is a part. In this case, the documentation would be the policies and procedures of the city, county, or state government, for example.

  Likewise, the health department may be part of a "Super Public Health Agency," a "Super Health Agency," or "Umbrella Agency" (i.e., an agency that oversees public health and some combination of primary care, substance abuse, mental health, Medicaid, and other human service programs). For example, the health department's human resource policy and procedures manual could be the manual of the Super Public Health Agency, Super Health Agency, or Umbrella Agency, of which it is a part. The functions associated with the 10 Essential Public Health Services may be contained in different divisions within the Umbrella Agency (i.e., a health department might have an environmental health division separate from the public health services division). In those cases, the applicant

may use examples from any division of the Super Agency that carries out a public health function and falls within PHAB's Scope of Authority.

- **Tribal, local, and state health departments may have agreements with each other about the responsibility for and provision of public health functions.** For example, the state may provide the epidemiology function at the Tribal or local levels. In this case, to ensure that this function is still provided to the people in the jurisdiction, the health department may need to submit documentation demonstrating who is responsible for providing the function in the population. In some instances, **The Standards** indicate that some or all of the documentation for a measure is not applicable for certain health departments because that function is carried out by a different governmental entity. Health departments do not need to submit documentation for those requirements. If an entire measure is not applicable for a particular health department, that measure will be assessed as Not Applicable.

Requirements that are Not Applicable

The Standards indicate several places where requirements may not be applicable to particular health departments. In those instances, the health department will not submit documentation and they will not be assessed on that measure—or on a particular requirement within the measure. There are four scenarios where requirements may be Not Applicable:

- If the measure indicates it is only for one or two types of health departments, and the applicant is of a different type (e.g., the applicant is a local or Tribal health department and the measure is indicated as being state only; the applicant is a state health department and the measure is designated as being for local and Tribal health departments; the applicant is state health department in a state with no local health departments and PHAB has agreed that a particular requirement does not apply).
- If in the "Required Documentation" column, it says that specific documentation is not required for health departments in particular circumstances (e.g., the applicant does not carry out a particular function or that function is carried out by another governmental entity), the health department will indicate to PHAB through e-PHAB, that the health department meets those circumstances.
- If the applicant is currently recognized as Project Public Health Ready (PPHR), a criteria-based training and recognition program of the Centers for Disease Control and Prevention (CDC) and National Association of County & City Health Officials (NACCHO), that health department is exempt from submitting documentation to demonstrate conformity with Standard 2.2 requirements. Rather than submitting documentation for Standard 2.2, PPHR recognized health departments may choose to submit their "Letter of Recognition" or a screenshot from the NACCHO website demonstrating current PPHR recognition. Evidence must include a date and demonstrate recognition has not expired at the time documentation is submitted to PHAB.
- If PHAB indicates that documentation relevant to a particular health department has already been assessed and does not need to be assessed again. This may be the case if the health department participates in the Pathways Recognition Program, and the documentation meets the requirements outlined in the Policy for the Pathways Recognition program. It also might be the case if PHAB enters into an agreement with a state health department to review a state-level documentation once and not require local health departments to submit that same policy as part of their documentation submission. The agreement with PHAB will include the submission process.

Health departments are required to provide documentation for all other measures.

Scope of Authority

The Standards address the full array of public health functions and services described in the 10 Essential Public Health Services framework that are provided by governmental health departments. As a result, **The Standards** are focused on development and implementation of policies, systems, programs and services for disease prevention, health protection, and health promotion for the entire population and/or specific groups of the population in the health department's jurisdiction. While populations are comprised of individuals, PHAB will not accept documentation examples of policies, programs, or services that are delivered at the individual or single-family level. Instead, documentation examples must illustrate health department use of data, policies, systems, programs, and services to collaboratively improve the health of populations, address social determinants of health, and facilitate health equity.

Overarching Principles for Activities and Services that are within PHAB's Scope

The list below highlights the 10 Essential Public Health Services and their focus on improving the health of populations, consistent with activities covered by **The Standards**:

- **Assess and monitor population health.** The collection and analysis of data (even if the data are comprised of individual patient records) allow health departments to understand the health of the population and identify disparities across different subpopulations.
- **Investigate, diagnose, and address health hazards and root causes.** As health departments conduct surveillance and case investigations, they need to gather information from individuals in order to mitigate the spread of disease or address environmental factors that impact the health of populations.
- **Communicate effectively to inform and educate.** Health department communication and education efforts are designed to reach populations and subpopulations to improve community health.
- **Strengthen, support, and mobilize communities and partnerships.** Health departments collaborate with organizations and individuals in their communities to collectively promote the health of the population.
- **Enable equitable access.** To ensure the population has access to needed services, health departments engage in activities to develop, assess, and improve the systems that support delivery of those services and thus meet the collective needs of many individuals.
- **Build a diverse and skilled workforce.** A competent public health workforce is necessary to support the provision of population-based interventions.
- **Improve and innovate through evaluation, research, and quality improvement.** Efforts designed to evaluate, improve, apply evidence about, or innovate on interventions that are delivered on a population or subpopulation level (or the health department's infrastructure to support those interventions) are designed to increase impact on health of the population as a whole.
- **Build and maintain a strong organizational infrastructure for public health.** Administrative, management, and governance capacity comprise the foundation for health departments to promote health among populations they serve.

Overarching Principles for Activities and Services Outside of PHAB's Scope

In general, population-based interventions that correspond with the 10 Essential Public Health Services, as described above, are within PHAB's scope. The table on the next page shows principles about what PHAB's accreditation **does not** cover.

A Scope of Authority FAQ and addendum to the above Scope of Authority policy, illustrating how the above principles may be applied to documentation, can be found on PHAB's website (**www.phaboard.org**).

Overarching Principles for Activities and Services Outside of PHAB's Scope

1. Individual patient care, whether provided in the clinic, home, or other facility such as a school or correctional facility, is not included in PHAB's scope of authority. Similarly, clinical protocols that govern the provision of care to an individual are outside of PHAB's scope.	PHAB does not carry liability insurance related to assessment of the quality of individual patient care. Even though PHAB recognizes some health departments are the safety net providers in their communities, standards and measures that would assess patient care would look very different than population-based standards and measures. Additionally, for health departments who also operate a Federally Qualified Health Center (FQHC), there is an accreditation available through the Joint Commission (JC). For individual services and interventions related to mental or behavioral health interventions, health departments can also consider those specialty accreditations. For that reason, details about specific interventions delivered at the individual level are not acceptable (e.g., PHAB will not review documentation about protocols that govern the provision of medical care or counseling to individuals). However, development, assessment, or improvement of systems that support those interventions are acceptable, even if those systems are targeted to groups of individuals in settings like schools or correctional facilities, or health department client groups (e.g., WIC).
2. Administration of programs for reimbursement of health care services, such as Medicaid or other health care insurance programs are outside the scope of PHAB accreditation.	These programs have oversight from either the Centers for Medicare & Medicaid Services (CMS) or from state insurance commissions or authorities. However, data analysis and systems designed to increase access to health insurance are in scope.
3. Individual professional and facilities licensure and certificate programs are outside the scope of PHAB accreditation.	Individual professional and facilities licensure and certificate programs are unique to state licensure laws and are overseen accordingly. Health facilities licensure and certification activities are not included in PHAB's accreditation standards because oversight is often a combination of federal contracting, state law, and state or local rules and regulations. This also pertains to Certificate of Need (CON) functions. However, data analysis and quality improvement related to these programs are in scope.
4. Programs designed to improve health or well-being of animals, such as animal shelters or animal cruelty prevention programs, are outside the scope of PHAB accreditation.	PHAB has no standards that relate to animal health; however, to the extent that animal-related programs (i.e., rabies vaccination) have an impact on human health, they are acceptable.

TERMINOLOGY

The Standards are accompanied by a sourced PHAB Acronyms and Glossary of Terms, which contains many of the terms used in this document. Below is a description of how two terms that are frequently used in **The Standards**—community and governance—are interpreted.

Community

PHAB has adopted the following definition of community: Community is a group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making and action. (Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009.) As indicated in this definition, the community could change depending on the context.

In **The Standards**, there are times when PHAB provides a specific definition for community, including:

- **The Standards** use the term "community health assessment" to refer to assessment at the state, Tribal, or local level. For state health departments, this is often referred to as a state health assessment and will assess the health of all residents in the state. For local health departments, the community health assessment will assess the health of residents within the jurisdiction it serves. A local health department's assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health assessment is often referred to as a Tribal health assessment and will address the health of the community as defined by the Tribal health department. For example, it may address the health of all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.
- **The Standards** use the term "community health improvement plan" to refer to planning at the state, Tribal, or local level. For state health departments, this is often referred to as a state health improvement plan and will address the needs of all residents in the state. For local health departments, the community health improvement plan will address the needs of the residents within the jurisdiction it serves. A local health department's plan may address the needs of residents within a larger region, but the submitted plan will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health improvement plan is often referred to as a Tribal health improvement plan and will address the community as defined by the Tribal health department. For example, it may address the needs of all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

In other instances, the health department will determine what community(ies) is appropriate, whether it is the entire jurisdiction or a subpopulation (e.g., a neighborhood or individuals who are higher health risk).

Governance

While **The Standards** do not assess the functioning of governing entities, there are requirements about the ways in which the health department interacts with those entities that play a public health governance role. Per the PHAB Glossary, "A governing entity is the individual, board, council, commission or other body with legal authority over the public health functions of a jurisdiction of local government; or region, or district or reservation as established by state, territorial, or tribal constitution or statute, or by local charter, bylaw, or ordinance as authorized by state, territorial, tribal, constitution or statute." (National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. **www.cdc.gov/nphpsp/PDF/Glossary.pdf**.) The health department may have multiple governing entities (e.g., city council, county commissioners) or entities that serve in an advisory role. For example, a health department's governing entity may be the board of health, but approval of ordinances or budgetary items may fall under the authority of a city council, county commissioners, or district advisory committee. In addition, a health department may be legally mandated to have one or more advisory boards to provide guidance on decision making about overall health department operations or public health in the jurisdiction. (Advisory boards that focus on a specific program area would not apply.)

Because each of these entities plays a role in decision making that affects the health department and the population it serves, **The Standards** has requirements related to a variety of entities that play a governance role. The "Required Documentation" column will indicate which part of the health department's governance must be included in the documentation.

PUBLIC HEALTH SYSTEM CONSIDERATIONS

State Health Department Applicants in Centralized States

For state health department applicants in centralized states, the focus of the documentation is on policies, plans, and systems that are state-wide. For example, the health assessment and the health improvement plan will cover the entire jurisdiction of the state. Documentation about the relationship between the health department and the governing entity will apply to the state-level governing entity. The performance management system would have objectives about the state's population or the operations of the health department throughout the state. Policies must apply to the central office of the applicant health department—policies may also apply to offices in local jurisdictions. The "Required Documentation" column will indicate if the documentation must demonstrate how staff serving in local jurisdictions are included (e.g., how a policy is applied or distributed to local jurisdictions). If the "Number of Examples" column calls for an example, that example may show implementation at a local level.

In several places in **The Standards**, state health departments are asked to demonstrate how they understand and are responsive to the needs of Tribal and local health departments. In these instances, applicants can provide evidence of working with Tribal health departments or with local or regional offices within the health department; documentation of working with program divisions within the state health department's centralized office would not meet the intent.

States with No Local Health Departments

A state with no local health departments may provide local public health services or programs directly to the population or through local units (sometimes called, for example, regions, district offices, or divisions). States with no local health departments should consult with PHAB about measures that require demonstrating support for local health departments within the state. If there are local units within the state (e.g., regional or local offices), documentation of support to those units may be appropriate. However, if PHAB determines that some requirements are not applicable in a given state with no local health departments based on conversations with that state, instructions will be provided about what to submit.

Tribal Sovereignty

There are 565 federally recognized Tribes (U.S. Federal Register) in the United States, each with a distinct language, culture, and governance structure. Native American Tribes exercise inherent sovereign powers over their members and territory. Each federally recognized Tribe maintains a unique government-to-government relationship with the U.S. Government, as established historically and legally by the U.S. Constitution, Supreme Court decisions, treaties, and legislation. No other group of Americans has a defined government-to-government relationship with the U.S. Government. See U.S. Constitution Article I, Section 8.

Treaties signed by Tribes and the federal government established a trust responsibility in which Tribes ceded vast amounts of land and natural resources to the federal government in exchange for education, healthcare, and other services to enrolled members of federally recognized Tribes. The

Indian Health Service (IHS), among other federal agencies, is charged with performing the function of the trust responsibility to American Indians and Alaska Natives. (See Section 3 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. § 1602.) Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975 (ISDEAA), provides the authority for Tribes (includes Alaska Native villages, or regional or village corporations, as defined in or established pursuant to the Alaska Native Claims Settlement Act) to enter into contracts or compacts, individually or through Tribal organizations, with the Secretary of Health and Human Services to administer the health programs that were previously managed by the Indian Health Service. More than half of the Tribes exercise this authority under the ISDEAA and have established Tribal Health Departments to administer these programs, which are often supplemented by other public health programs and services through Tribal funding and other sources.

In recognition of Tribal data sovereignty, there are several places in **The Standards** that explicitly indicate that Tribal health department applicants may provide alternative documentation. For example, Tribal health departments are not required to post their community health assessments online.

Territorial Health Departments

Territorial health departments should consult with PHAB about the applicability of particular measures.

DOMAIN 1

Assess and monitor population health status, factors that influence health, and community needs and assets.

Domain 1 focuses on the ongoing assessment of the health of the population in the jurisdiction served by the health department. The domain includes: a continuous and systematic approach to monitoring health status; collection, analysis, and dissemination of data; use of data to inform public health policies, processes, and interventions; and participation in a collaborative process for the development of a shared, comprehensive health assessment of the community, its health challenges, and its resources. The collection and analysis of data about the health status of the community informs the identification of health disparities and factors that contribute to them in order to develop strategies to achieve equity.

DOMAIN 1 INCLUDES **THREE** STANDARDS		
Standard 1.1:	Participate in or lead a collaborative process resulting in a comprehensive community health assessment.	
Standard 1.2:	Collect and share data that provide information on conditions of public health importance and on the health status of the population.	
Standard 1.3:	Analyze public health data, share findings, and use results to improve population health.	
FOUNDATIONAL CAPABILITY MEASURES:		
Assessment & Surveillance	**1.1.1 A:**	Develop a community health assessment.
	1.2.1 A:	Collect primary non-surveillance data.
	1.2.2 T/L:	Participate in data sharing with other entities.
	1.2.2 S:	Engage in data sharing and data exchange with other entities.
	1.3.1 A:	Analyze data and draw public health conclusions.

STANDARD 1.1

Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

A community health assessment (CHA) paints a comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health. Community health assessments are comprised of data and information from multiple sources, which describe the community's demographics; health status; morbidity and mortality; socioeconomic characteristics; quality of life; community resources; behavioral factors; the environment (including the built environment); and other social and structural determinants of health status.

Development of a CHA involves a systematic process to collect data and information that provides a sound basis for decision-making and action. In order to alleviate health disparities among subpopulations, the CHA gleans data and information to understand the factors and root causes that contribute to higher health risks and poorer health outcomes to inform strategies and plans to enable all community members to attain their optimal health. The CHA can help frame the narrative to emphasize the conditions that create health and cause disparities in health outcomes. It is important that the CHA be developed by the community, for the community. For this reason, it is important that community members or organizations that represent populations who are at risk or have been historically excluded or marginalized, participate in the health assessment process and are provided with key findings from the assessment in a manner they understand.

A collaborative approach to developing the CHA in partnership with other organizations and members of the community provides opportunities to develop a shared understanding among the public health system of the community's health needs and assets. The CHA provides valuable insight to inform the basis of community health improvement plan strategies.

The Standards use the term "community health assessment" to refer to assessment at the state, Tribal, or local level. For state health departments, this is often referred to as a state health assessment and will assess the health of all residents in the state. For local health departments, CHA will assess the health of residents within the jurisdiction it serves. A local health department's assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health assessment is often referred to as a Tribal health assessment and will address the health of the community as defined by the Tribal health department. For example, it may address the health of all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

MEASURE 1.1.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Develop a community health assessment.

Purpose & Significance

The purpose of this measure is to assess the Tribal, local, or state health department's comprehensive community health assessment of the population of the jurisdiction served by the health department. The community health assessment tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population.

A health assessment identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the community health assessment may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods.

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
1. Community health assessment (CHA) that must include **all** of the following elements:	This may be referred to as a state health assessment, Tribal health assessment, health needs assessment, or other name. A community health assessment differs from a statistical report in that it is developed collaboratively and with the express purpose of using data collected to draw conclusions about the health status, challenges, and assets of the population served in order to inform the prioritization of policies, strategies, and interventions. As such, this process requires not only the collection but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders. The collaborative partnership may determine that the community health assessment be updated on a different schedule, such as every 3 years. Dynamic community health assessments (i.e., websites with continuously updated data) are acceptable, if they address required elements a-g. In these cases, the health department is building on past data that have been collected and adding to those data over time. The partnership would meet on a periodic basis to review the data that are being collected and determine if there are any changes in data collection or interpretation. A combination of webpage screenshots and other documentation and descriptions may be used to demonstrate the required elements. As dynamic community health assessments may be updated more frequently, a description of the method and frequency of updates can be provided to meet the timeframe requirement, as long as the last updated date is within 5 years. Similarly, other formats of a CHA will be accepted, as long as required elements a-g are included. The intent of required elements a and b is to describe who is involved in the collaborative process to assess the health of the community and how they are involved. This could be included within, for example, the health assessment, an appendix, a partnership charter, or provided as a memo. **It is not necessary for the process description to be within the health assessment document itself.** Participating partners may engage in the CHA in a variety of ways. Participation could include, for example, serving on a steering committee or workgroup for conducting the CHA, contributing to data collection, or contributing to data interpretation. Involving impacted communities in the assessment will inform decisions about what data are collected and how they are interpreted in order to better understand the issues facing those communities, as well as resources or assets to address needs. The collaborative assessment will lay the groundwork for continued engagement in identifying and prioritizing potential solutions to improve community health (addressed in Measure 5.2.1 about the state/Tribal/community health improvement plan).		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
a. A list of participating partners involved in the CHA process. Participation must include: i. At least 2 organizations representing sectors other than governmental public health. ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.	**For required element a:** Partners that represent various sectors of the community could include, for example: hospitals, behavioral health, community clinics, and other health care providers; mortality review committees or boards; environmental public health groups; community foundations and philanthropies; volunteer organizations; religious organizations; community organizers and advocates; unions; parent-teacher associations, tenants, or volunteer organizations; or real estate representatives. The partnership will include community members directly or include organizations representing those populations who are disproportionately affected by conditions that create poorer health outcomes or for whom systems of care are not appropriately designed. Individuals or organizations that represent populations who have lived experiences with or are disproportionately affected by conditions that contribute to poorer health outcomes could include, for example: historically excluded or marginalized population groups, communities of color, indigenous communities, LGBTQ populations, individuals with limited English-speaking abilities, individuals with disabilities, immigrants, refugees, aging populations, or individuals who are blind, deaf, or hard of hearing. Organizations that represent populations or have expertise addressing inequities could include, for example, local, state, or regional networks and agencies, not-for profits, or civic groups representing specific issues or subpopulations. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form—for example, to clarify who are community member representatives.) Partners in the CHA process may also include other public health entities, such as public health institutes, other health departments, or military installation departments of public health located in or near the health department's jurisdiction. Some examples of partners specific to the Tribal setting include other divisions within the Tribal government that may be outside the public health department division (e.g., environmental health, health care, or mental health). There may also be key partners who are external to the Tribal government, such as Tribal Epidemiology Centers; state or local health departments; or businesses. Tribal health departments may self-determine who the partners are and the number of partners that are most appropriate to include in the development of a community health assessment.		
b. The process for how partners collaborated in developing the CHA.	**For required element b:** The process will describe how partners engaged, which could include, for example, recruitment of participants, roles of participants, frequency of meetings or other methods of convening partners, or use of engagement strategies such as stakeholder analysis or power mapping. The process could also describe, for example, the timeline for the assessment, or how data were assessed to draw conclusions about health issues and needs. The process may follow a national model; state-based model; a model from the public, private, or business sector; or other partnership and community participatory process model. Models could include, for example, Mobilizing for Action through Planning and Partnership (MAPP; NACCHO), Association of Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), SHIP Guidance and Resources (ASTHO), or the University of Kansas Community Toolbox. Required elements c-g are the data and information that comprise the assessment itself.		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
c. Comprehensive, broad-based data. Data must include: i. Primary data. ii. Secondary data from two or more different sources.	**For required element c:** Primary data are data for which collection is conducted, contracted, or overseen by the health department or CHA partnership. The CHA will indicate which data are primary by, for example, describing the methodology for data collection or listing the health department or CHA partnership as the data source. Data collection methods could include, for example, asset mapping, community forums, community listening sessions, surveys (e.g., surveys of high school students or parents), or focus groups (e.g., sessions discussing community health issues). Such information often provides additional context or details to help interpret secondary data sets. Non-traditional and non-narrative data collection techniques are acceptable forms of data collection. For example, an assessment could include photographs taken by members of the Tribe or community in an organized assessment process (e.g., photovoice) to identify environmental (including the built environment) health challenges, causal loop diagrams, iceberg models, or use of empathy mapping or ethnographic interviews to gather an understanding of current and historical inequities and their impact. Secondary data sources might include federal, state, Tribal, and local data. If the data collection is conducted, contracted, or overseen (i.e., the data collection instruments are designed) by the health department or the CHA partnership as a whole, it would not meet the intent of the element. However, data collected by a single partner of the collaborative (e.g., EHR data from a hospital that is part of the CHA partnership) would be appropriate. Specific secondary data sources could include, for example, Behavioral Risk Factor Surveillance Survey (BRFSS)/Youth Risk Behavior Surveillance (YRBSS) (if not collected by the health department), County Health Rankings, CDC Disability and Health Data System, CDC Social Determinants of Health (SDOH) and PLACES Data, US Census American Community Survey or Factfinder, AHRQ Social Determinants of Health Database, HRSA Area Health Resource Files, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, PH WINS, SAMHSA's Behavioral Health Barometer, CityHealth, or Tribal Epidemiology Center data. Other secondary sources could include: vital statistics (if not collected by the health department); notifiable conditions data; clinical and administrative data collected by hospitals and/or health care providers, such as hospital discharge rates or insurance claims; local and state chart of accounts; data from local schools, academic institutions, or other departments of government (e.g., recreation, public safety, environment, housing, transportation, labor, education, or agriculture); or data from community not-for-profits (e.g., Aging and Disability Resource Centers), 211 data, community narrative, or other sources of nontraditional community information.		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
d. A description of the demographics of the population served by the health department, which must, at minimum, include: i. The percent of the population by race and ethnicity. ii. Languages spoken within the jurisdiction. iii. Other demographic characteristics, as appropriate for the jurisdiction.	**For required element d:** In addition to ethnic and racial composition and languages spoken, demographic information could also include, for example, gender, age, socioeconomic factors, income, disabilities, mobility (travel time to work), educational attainment, home ownership, employment status, immigration status, or sexual orientation.		
e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following: i. Health status. ii. Health behaviors.	**For required element e:** The intent of required element e is to present a summary of themes and findings based on the data in required element c, above. To examine what disparities may exist in the health status in the community, the CHA could include differences in rates of, for example, illness, death, chronic conditions, self-reported health and well-being, and other types of health outcomes in relationship to demographic factors (e.g., race, ethnicity, gender, sexual orientation, disability status or special health care needs, or geographic location). Similarly, the CHA will examine differences in health behaviors, for example, smoking or vaping rates, eating or exercise habits, or high-risk sexual behavior. Examples of ways the data could be presented include, for example, a table, or cross-tabulation that demonstrates differences in chronic disease morbidity by race and ethnicity; differences in smoking rates by age; or a map showing poorer health outcomes by zip code. It could also include a description of how themes from focus groups or townhalls varied based on neighborhood or demographics of participants.		

MEASURE 1.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 community health assessment	**Dated Within** 5 years
f. A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment.	**For required element f:** Health equity relates to social justice in health; that is, everyone has a fair and just opportunity to be as healthy as possible. The description of factors that contribute to inequities may relate to conditions that vary by population, for example, the availability of affordable housing for low- and middle-income families; availability of culturally and linguistically appropriate services for limited English-speaking populations; or how conditions vary by neighborhood such as school funding or access to health services. Inequities related to the built environment might include vulnerability to climate change, or the availability of grocery stores, parks, sidewalks, or transportation. As part of identifying factors that contribute to health challenges within the community, the description may also address related policies (e.g., taxation, education, transportation, or insurance status), social or structural determinants of health, or other the unique characteristics of the community that impact health status. Social determinants of health include factors in which people are born, live, and grow that influence health beyond a person's control. Social determinants **may** include structural determinants or "root causes" of health inequities. Structural determinants include factors such as the political, economic, or social policies that affect income, education, or housing conditions. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual orientation, or other socially defined group of people. The description could include equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes.		
g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges. The CHA must address the jurisdiction as described in the description of Standard 1.1.	**For required element g:** The intent of this required element is to ensure that when assessing the health of the community, the partnership is also learning about the assets and resources that can enhance community well-being. The CHA does **not** need to include an exhaustive list of all assets. A section may be dedicated to assets or resources, as a list or narrative, or they may be woven throughout the document. Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, or mutual aid groups or support circles. Inta-ngible assets and resources could also be included. The CHA could spotlight strengths including, for example, stories that demonstrate community leadership, examples of social cohesion, or indications of social capital (e.g., number and diversity of civic organizations).		

MEASURE 1.1.2 A:

Ensure the community health assessment is available and accessible to organizations and the general public.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to share the community health assessment with other organizations and the general public. The community health assessment is a resource for all members of the public health system and the population at-large. It serves as a foundation for community-wide collaboration, priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets and resources to improve population health. Other governmental units and not-for-profits may use the community health assessment in their planning, partnership and program development, and development of funding applications.

MEASURE 1.1.2 A:

Required Documentation 1

1. Key findings **and** the full community health assessment (from Measure 1.1.1) actively shared with others.

One example must show actively informing organizations including those that are **not** members of the community health assessment partnership. The other example must show actively informing the public.

Guidance

Number of Examples
2 examples

Dated Within
5 years

The intent of this requirement is to demonstrate **active** methods of informing the public and stakeholders, governmental agencies, associations, or other organizations about the key findings **and** availability of the community health assessment. Passive methods of sharing, such as, posting the CHA on a website alone would **not** be sufficient to demonstrate active sharing for this requirement. Instead, the health department could demonstrate active sharing through, for example, presentations or press releases to share key findings and where to access the assessment.

Key findings could include, for example, a summary of key points, an executive summary portion of the full assessment, a letter summarizing findings, infographic, or data visualization.

Tribal health departments should ensure that the community health assessment is available to the broadest community possible in the context of the Tribal setting. In respecting the sovereignty of the Tribe to make the most appropriate decision about sharing reports from its data, PHAB does not require that Tribal health departments post their community health assessment on their website. However, documentation must be submitted that indicates with whom the CHA was shared and how it was shared.

Documentation Examples

Documentation of notification of **organizations** could be, for example, copies of emails to partners and stakeholders providing information of how to access the assessment which includes key findings; or meeting minutes showing discussion of where and how partners and stakeholders can access the assessment as well as key findings. The Documentation Form could provide clarification about the organizations, for example, to explain which email recipients or meeting participants were not part of the CHA partnership.

Documentation of notification **to the public** could be, for example, evidence of hard-copy distribution of the community health assessment's key findings (with information on how to access the full report) to libraries or a press release including instructions for accessing the community health assessment and its key findings. Links to the CHA and key findings could be, for example, published in newspapers, included in the department's external newsletter, included in a public service announcement, discussed in TV or radio interviews, or included in a social media post.

STANDARD 1.2

Collect and share data that provide information on conditions of public health importance and on the health status of the population.

Reliable data are critical to public health programs, operations, and infrastructure. The ability to collect and access timely and reliable data equips health departments with information to assess health status and disparities, inform decision-making, and evaluate programs and services. Health departments require data from multiple sources, including data from other organizations in order to form a complete picture of the health of the population that can be compared between populations and over time.

MEASURE 1.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Collect non-surveillance population health data.

Purpose & Significance

The purpose of this measure is to assess the health department's capacity to collect primary data to understand the health issues of the population served, which may include exploration of health disparities or contributing factors or causes of health challenges. Health departments may require additional data to supplement what can be learned from existing data sets to better understand specific situations, issues, and potential solutions. Collection of primary data does not need to be complicated or costly. Rather, it is intended to enhance knowledge and understanding of the population served by the health department. These data may address social conditions that have an impact on the health of the population served, for example, unemployment, poverty, lack of accessible facilities for physical activity, housing, transportation, and lack of access to fresh foods. Health departments need to demonstrate capacity to collect primary data or ensure they have access to another entity that can collect primary data on their behalf.

MEASURE 1.2.1 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Primary **quantitative** population health data collected for the purpose of understanding health status in the jurisdiction, including:	Primary data are data for which collection is conducted, contracted, or overseen by the health department.If the health department provides funding for data collection, has a formal agreement for data collection (e.g., with a Tribal Epidemiology Center), or works with another entity on the design or implementation of the data collection instrument, the data collected would be considered primary and would meet the intent of this requirement. For health departments that are part of an umbrella agency, population health data collected by another division of the umbrella agency would also be considered primary. Surveillance data, program evaluation, and customer satisfaction do **not** meet the intent of this requirement. If the health department's role in data collection is not evident in the example, it can be clarified in the Documentation Form. Surveys can be used to collect both quantitative data (e.g., responses to multiple choice questions, true or false questions, questions with a Likert scale or other form of rating, or questions that ask for a numerical answer) and qualitative data (e.g., open-ended questions). If the data collection instrument includes both quantitative and qualitative data, the same instrument (required element a) can be used as one of the examples required for both Required Documentation 1 and Required Documentation 2. If using the same instrument, the Documentation Form will indicate where the quantitative questions are in the instrument.		
a. Data collection instrument.	**For required element a:** Data collection instruments are standardized tools from the standpoint that the same tool is used with all respondents. For example, a local survey developed and distributed to a representative sample of potential respondents within the jurisdiction or data collected using BRFSS or YRBSS survey instruments could be used. Primary quantitative data could be obtained from surveys of target groups (e.g., teenagers, jobless individuals, or residents of a neighborhood with higher risks of poor health outcomes).		
b. Evidence that instrument was used to collect data. Data must provide information about the health status of the population or the factors contributing to the health status.	**For required element b:** Documentation of the use of the instrument could include, for example, screen shots or spreadsheets showing the **quantitative** data that were collected (as long as no confidential or sensitive information is included), email or letter inviting individuals to participate in the survey, or findings based on the **quantitative** data collected using the tool provided in element a (e.g., reports, presentations, copies of meeting minutes showing briefings or summaries of findings, or excerpts from the state/Tribal/community health assessment).		

MEASURE 1.2.1 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
2. Primary **qualitative** population health data collected for the purpose of understanding health status in the jurisdiction, including:	Primary data are data for which collection is conducted, contracted, or overseen by the health department. If the health department provides funding for data collection, has a formal agreement for data collection (e.g., with a Tribal Epidemiology), or works with another entity on the design or implementation of the data collection instrument, the data collected would be considered primary and would meet the intent of this requirement. For health departments that are part of an umbrella agency, population health data collected by another division of the umbrella agency would also be considered primary. Program evaluation and customer satisfaction data do **not** meet the intent of this requirement. If the health department's role in data collection is not evident in the example, it can be clarified in the Documentation Form. Surveys can be used to collect both quantitative data (e.g., responses to multiple choice questions, true or false questions, questions with a Likert scale or other form of rating, or questions that ask for a numerical answer) and qualitative data (e.g., open-ended questions). If the data collection instrument includes both quantitative and qualitative data, the same instrument (element a) can be used as one of the examples required for both Required Documentation 1 and Required Documentation 2. If using the same instrument, the Documentation Form will indicate qualitative questions in the instrument.		
a. Data collection instrument.	**For required element a:** Data collection instruments are standardized tools from the standpoint that the same tool is used with all respondents. For example, an interview or focus group guide used with a representative sample of potential respondents. Primary qualitative data collection methods could include, for example, open-ended survey questions, community or town forums, listening sessions, focus groups, storytelling, group interviews, stakeholder interviews, or key informant interviews.		
b. Evidence that instrument was used to collect data. Data must be collected directly from groups or individuals who are at higher health risk. The collected data must provide information about the health status of the population or the factors contributing to the health status.	**For required element b:** Documentation of the use of the instrument could include, for example, transcripts or notes from focus groups or town halls, screen shots or spreadsheets showing the **qualitative** data that were collected (as long as no confidential or sensitive information is included), email or letter inviting individuals to participate in a survey or focus group, flyer about a town hall, or findings based on the **qualitative** data collected using the tool provided in element a (e.g., reports, presentations, copies of meeting minutes showing briefings or summaries of findings, or excerpts from the state/Tribal/community health assessment).		

MEASURE 1.2.2 T/L:

FOUNDATIONAL CAPABILITY MEASURE

Participate in data sharing with other entities.

Purpose & Significance

The purpose of this measure is to assess the **Tribal or local health department's** ability to participate in data sharing among health departments and other entities. A complete picture of the health of the population requires data from multiple sources (e.g., from federal, state, Tribal, and local health departments; health care; education; criminal justice; transportation; or social services). Sharing and receiving data are key steps in generating a better understanding of health within the jurisdiction. To ensure data are shared throughout the public health system, state health departments also have a PHAB measure related to data sharing and exchange.

MEASURE 1.2.2 T/L:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	2 years

1. Participation in data sharing with other entities, by either:
   a. Providing data to another entity; **or**
   b. Receiving data from another entity; **or**
   c. Providing a data use agreement with another entity.

The data being shared must include record-level data.

The intent of the requirement is to demonstrate sharing or receiving data that can be used to gain new insights by enabling the recipient of those data to conduct analyses looking for relationships among the data points or potentially to merge the data with other data sets. Sharing data summaries or aggregate data would **not** meet the intent of this requirement. Instead, the data will include record-level data. That is, there would be data for each unit (e.g., each individual, jurisdiction, facility, body of water or other specimen collection site, or clinic) in the dataset. For example, the health department could receive a dataset with a row of information about each patient from a local hospital, which the health department could use to analyze relationships (e.g., relationships between disease prevalence and the patients' zip code or demographics). The data could also be used to assist in outbreak containment by sharing surveillance data with another health department, for example. Data that the health department receives from other entities could include, for example, school performance or absences, capacity of licensed childcare facilities, land use zoning, receipt of public benefits, eviction notices, building inspections or complaints, calls to the fire department or emergency services, or utilization of public transportation options. Sharing deidentified data (i.e., data where the names or other information that would identify individuals has been removed) would be acceptable.

The entity could be, for example, an organization, an individual, another local or Tribal health department, or the state health department.

Data could be submitted or received through a data system. Data systems could include, for example, registries (e.g., cancer registries or immunization registries); vital records data; or data in web-based infectious disease reporting systems. Electronic heath record (EHR) data could also be considered if, for example, the data from an EHR operated by the health department are made available to other providers through a health information exchange or if the health department is able to access EHR data from other providers through a health information organization. Submitted or received data could also be shared outside of a data system, such as providing environmental public health data (e.g., a data set including information about water quality readings over time or across sites) through email.

The documentation could be provided via an intermediary. For example, a Tribal health department could provide documentation demonstrating that they work with a Tribal Epidemiology Center to establish data sharing.

In respecting the sovereignty of the Tribe to make the most appropriate decision about sharing data, Tribal health departments can determine whether and under which circumstances to share their data.

Documentation Examples

Documentation could be, for example, emails, screen shots documenting data were shared or received through web pages or a portal, or data use agreements.

MEASURE 1.2.2 S:

FOUNDATIONAL CAPABILITY MEASURE

Engage in data sharing and data exchange with other entities.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** capacity to share data in response to requests, as well as its ability to engage in ongoing exchange of data using interoperable systems. Data collected by the state health department should be available to researchers and others to analyze, for example, differences in health status or health behaviors by demographics or social and environmental factors. Participating in ongoing public health data exchange (e.g., electronic case reporting, electronic laboratory reporting) is essential for gaining real-time insights for the rapid detection of current and potential health hazards and threats. The effective exchange of data requires use of data standards to automate the transfer of critical data in real-time.

MEASURE 1.2.2 S: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
1. A data use process that includes:	The intent of the requirement is to demonstrate that the state health department has a process in place to ensure data are made available to health departments and other individuals or organizations when requested, including how the state health department monitors that data requests have been resolved. Sharing or receiving data can be used to gain new insights by enabling the recipient of those data to conduct analyses by looking for relationships among the data points or potentially merging those data with other data sets. The process for sharing data summaries or aggregate data would **not** meet the intent of this requirement. Instead, the data will include record-level data. That is, there would be data for each unit (e.g., each individual, jurisdiction, facility, body of water or other specimen collection site, or clinic) in the dataset, which would enable the recipient of those data to conduct analyses or look for relationships among the data points. If the health department uses different processes for different types of data (i.e., one policy for vital records data and another for reportable diseases), only one process is required.		
a. A description of how the health department makes data and supporting materials available to others upon request.	**For required element a:** The process may be included as part of a larger policy, or standalone document. The process will address data requests, beyond public or open record requests. Supporting materials will include information necessary to help the recipient use the data and could be, for example, a data dictionary, a codebook, or an FAQ about the data. The process is **not** required to include a comprehensive list of supporting materials available, but could describe, for example, the types of supporting materials or the process for making sure appropriate materials are available.		
b. A description of the steps the health department takes to maintain confidentiality as appropriate.	**For required element b:** Documentation could include, for example, data use agreements that outline steps the data recipient must take to protect the confidentiality of the data or a description of how the health department reviews data requests to ensure appropriateness.		
c. The process used to ensure requests receive responses. The process must describe sharing record-level data. This process must pertain to data requests from both other health departments and from other individuals or organizations.	**For required element c:** The process to ensure the requests are resolved might address how a tracking log or other process is maintained and used.		

MEASURE 1.2.2 S: Required Documentation 2	Guidance	Number of Examples: 1 list	Dated Within: 5 years
2. List of data standards used for data exchange. The standards must be developed and maintained by national or international standards development organizations. The list could be provided in the Documentation Form.	The intent of the requirement is to demonstrate that the state health department is using recognized health data standards within their systems to increase semantic interoperability (e.g., the ability of data to be shared with unambiguous meaning) with other internal and external partner systems. Standards used to codify, package, and transport data that are developed and maintained by national or international standards development organizations include, for example: ▪ Vocabulary/Terminology standards (e.g., Logical Observation Identifiers, Names and Codes (LOINC), ▪ Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), and RxNorm) ▪ Content standards (e.g., Health Level Seven (HL7)) ▪ Transport standards (e.g., Fast Healthcare Interoperability Resources (FHIR®) and Direct StandardTM)		

MEASURE 1.2.2 S: Required Documentation 3	Guidance	Number of Examples: 1 example of exchanging data with each of the following: the federal government, another health department, another entity (1 example could address multiple types of organizations)	Dated Within: 5 years
3. Capacity to exchange data electronically with each of the following:	The intent of this requirement is to demonstrate the ability to use electronic systems to exchange data with other entities. An example of responding to a single request for a dataset would **not** meet the intent of this requirement. One of the examples will show how the health department both receives and sends data electronically. The other two examples could be for just one-way exchange (i.e., either the health department sending or receiving data). Documentation could be, for example, descriptions of the data exchange mechanism or screenshots of a system. If the health department is participating in a health information exchange (for example, a regional health information organization) that includes both other health departments and non-health department entities, then one example can be used for both required elements b and c.		
a. Federal government.	**For required element a:** Federal agencies could include, for example, the CDC, CMS, or USDA.		

MEASURE 1.2.2 S: **Required Documentation 3**	**Guidance**	**Number of Examples** 1 example of exchanging data with each of the following: the federal government, another health department, another entity. (1 example could address multiple types of organizations)	**Dated Within** 5 years
b. Other state, local, or Tribal health departments.	**For required element b:** The health department could demonstrate data exchange with other state health departments or with local or Tribal health departments.		
c. Other entities. At least one of the examples must include bidirectional data exchange.	**For required element c:** Other entities could include, for example, health care providers, or laboratories.		

MEASURE 1.2.3 S:

Facilitate use of statewide data systems

Purpose & Significance

The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in participating in statewide data systems. States maintain data systems (e.g., statewide registries, vital records systems) that are critical for capturing information about the health of the state. State health departments should support Tribal and local health departments in providing accurate and timely data through these systems. To facilitate use of these data throughout the state, the state health departments should have mechanisms through which Tribal and local health departments can access data generated through those systems.

MEASURE 1.2.3 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
1. Data provided to Tribal and local health departments based on statewide data systems in which the Tribal and local health department participates. One example must be with a Tribal health department participating in the statewide data system if one exists in the state. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the Documentation Form and two examples with local health departments must be provided.	Tribal or local health departments report data into statewide systems (e.g., registries, vital records, or surveillance systems). Receiving data back from those systems allows for greater use in planning and action at the local level. **Documentation Examples** Documentation could be, for example, data from an immunization registry showing the data from a Tribal or local health department's jurisdiction (or a subset of the jurisdiction such as a zip code, city, or town), accompanied by documentation of the data's distribution to that health department. Alternatively, documentation could be a summary of data from the vital records systems that shows birth data for each county in the state, accompanied by evidence it was distributed to all county health departments. If the data are available in a portal that local and Tribal health departments have access to, the documentation could be a screenshot of that system, accompanied by an email, meeting minutes, or other evidence that the state health department has explained to other jurisdictions how they can access the portal.		

MEASURE 1.2.3 S:	Guidance	Number of Examples	Dated Within
Required Documentation 2		2 examples	5 years
2. Information sought or reviewed to understand how to support Tribal and local health department participation in statewide data systems. Information must be sought or reviewed about at least one Tribal health department and one local health department. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the Documentation Form and two examples with local health departments must be provided.	The intent of this requirement is for the state health department to develop an understanding about what might support Tribal and local health departments in using statewide data systems, which include, for example, statewide registries, vital records systems, surveillance systems. Seeking information could include, for example, efforts by the state to ask local and Tribal health departments about technical assistance needs, barriers, or suggestions on system modifications that would make the system more usable through a survey, phone call, or meeting. If the state health department can document that it asked for feedback, it is **not** necessary to demonstrate that feedback was received. Other examples of gathering or seeking information could include, for example, reviewing requests or questions that the state health department received from local or Tribal health departments, or reviewing existing sources of information on common barriers faced by Tribal and local health departments (e.g., data about common errors or bugs encountered by local or Tribal health departments using the systems), or engaging local and Tribal health departments in the development of new systems to ensure their feedback is reflected in requirements. The state health department **cannot** use examples of seeking information about program divisions within the state health department's central office and their needs. In a centralized state, the examples could be information from or about staff serving local jurisdictions or Tribal health departments. **Documentation Examples** Documentation of seeking information could be, for example, emails, phone call minutes, newsletters, memos, meeting minutes, notes from conversations (e.g., Council or Nations leadership meetings), or results of a survey with questions designed to understand the needs and participation among Tribal and local health departments in statewide data systems. If the health department uses an existing source of information (e.g., a list of questions or bugs), the documentation could be supplemented with an explanation in the Documentation Form about how this information was reviewed.		

MEASURE 1.2.3 S:	Guidance	Number of Examples	Dated Within
Required Documentation 3		2 examples	5 years

3. Support provided to Tribal and local health departments to be responsive to their needs regarding participation in statewide data systems. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the Documentation Form and two examples with local health departments must be provided.	State health departments play a critical role in ensuring Tribal and local health departments understand their access to and use of statewide data systems. Support provided could include, for example, guidance on access to statewide data system software application licenses; support using or uploading data into statewide data systems; guidance about the most effective ways to download, interpret, analyze or present data from the statewide system; a learning community where users of the system could seek advice from each other; or assistance with using data visualization websites that include representations of the data from those systems. Providing access to data systems, alone, would **not** meet the intent of this requirement. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be support to staff serving local jurisdictions or to Tribal health departments. Examples could be related to the activities described in Required Documentation 2, but it does not need to be. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and that recognition of Tribal sovereignty was considered in communication or decision making. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is **not** required. The Documentation Form could describe, for example, a request for assistance made by the Tribal or local health department on a phone call, in a meeting, or through an email. **Documentation Examples** Documentation could be, for example, newsletters, memos, meeting minutes, presentations at conferences or webinars, phone call minutes, or software license agreements with emails showing assistance to support use of statewide data systems.

STANDARD 1.3

Analyze public health data, share findings, and use results to improve population health.

Data analysis involves the examination and interpretation of data with the goal of drawing conclusions that inform planning, decision-making, program development, evaluation, and quality improvement. The purpose of data analysis is to identify and understand current and emerging health challenges and the factors contributing to them. Data can identify trends in behaviors, disease incidence, opinions, socioeconomic status, the environment (natural and built), and other factors.

The way the findings are shared can also help shape the narrative to put an emphasis on the conditions that create health and cause disparities in health outcomes. The design and evaluation of public health policies, processes, programs, and interventions should be informed by the use of public health data. Data findings should be shared with others for use in health improvement efforts.

MEASURE 1.3.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Analyze data and draw public health conclusions.

Purpose & Significance

The purpose of this measure is to assess the health department's capacity for data analysis to increase understanding of health problems, behavioral risk factors, environmental public health hazards, social and economic conditions, or other factors that affect the public's health. Analysis of data is important for assessing the contributing factors, magnitude, geographic location, changing characteristics, and potential interventions of a health problem. Data analysis is critical for problem identification, program design, evaluation, and continuous quality improvement. By comparing data from different subpopulations or different geographic locations, the health department can also understand where to focus interventions or allocate resources.

MEASURE 1.3.1 A: Required Documentation 1	Guidance	Number of Examples: 1 example	Dated Within: Analysis conducted within 5 years (data may be older)
1. Conclusions from **quantitative** analysis of data relevant to public health, which include:	The intent of this requirement is to show what has been learned from the analysis of quantitative data. Data used in the analysis can include all primary data, all secondary data, or a combination of primary and secondary data. The actual data set(s) used in the analysis do **not** need to be provided. The health department could use reports produced by others, such as the state health department, an academic institution, or other organizations. However, data analysis developed by others must have a connection to the jurisdiction and the populations served by the health department and contain information relevant to public health. Providing a spreadsheet of raw, unanalyzed data would not meet the intent of this requirement. Program evaluation, customer satisfaction, or employee satisfaction do **not** meet the intent of this requirement. Data relevant to public health may include social conditions that have an impact on the health of specific populations served, for example, unemployment, poor housing, lack of transportation, high crime residential areas, poor education, poverty, or lack of accessible facilities for physical activity. Data sources could include, for example, Behavioral Risk Factor Surveillance Survey (BRFSS) data, youth survey data (e.g., YRBSS), PLACES data portal, HUD Location Affordability Index, AHRQ Social Determinants of Health Database, USDOT Local Area Transportation Characteristics for Households (LATCH), USDA Food Environment Atlas, EPA Environmental Dataset Gateway, vital statistics, workplace fatality or disease investigation results, outbreak investigation results, environmental or occupational public health hazard data, key health indicator data, health disparities data, environmental data, socioeconomic data, stratified racial and ethnic health disparities data, hospital data, or not-for-profit organizations' data (for example, poison control center data). It can also include surveys that collect quantitative data (e.g., responses to multiple choice questions, true or false questions, questions with a Likert scale or other form of rating, or questions that ask for a numerical answer).		

MEASURE 1.3.1 A: Required Documentation 1	Guidance	Number of Examples 1 example	Dated Within Analysis conducted within 5 years (data may be older)
a. Comparisons.	**For required element a:** Documentation will include findings related to the comparisons, which could be presented, for example, in a graphic form (e.g., a bar graph that compares differences in the prevalence of various health conditions by socioeconomic status) or in a narrative (e.g., a paragraph that describes numeric or percentage differences survey responses based on the age of the respondents). Comparisons could include, for example (1) other similar socio-geographic areas, sub-state areas, the state, or nation, (2) different population groups, such as age, gender, race, SES, or (3) similar data for the same population gathered at an earlier time to establish trends over time (e.g., rates of sexually transmitted diseases over the past five years, childhood immunization rates over the past eight quarters, unemployment rates over the past five years, or crime rate over the past two years).		
b. The analytic process used. (If the analytic process used is not evident in the example, it could be indicated in the Documentation Form.)	**For required element b:** Analytic processes for quantitative data could be, for example, crosstabs (i.e., tables showing how the mean, median, or count varies by demographic category), tests of significance (T-test, chi-square, ANOVA), cluster analysis, factor analysis, or regression analysis. The intent of this element is to show that analysis has been conducted to understand the relationships between variables. This type of analysis can be conducted using spreadsheets and does **not** require the use of statistical applications. The analytic process may be indicated in the Documentation Form.		
c. Conclusions. At least some data used in the analysis must be specific to the population served by the health department or a subset of the jurisdiction's population.	**For required element c:** Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications for the community, drawing inferences about the relationship between different variables, or making hypotheses about potential causes of the findings. This could be presented as part of, for example, an executive summary, a list of recommendations, or a discussion or implications section of a report. **Documentation Examples** Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment.		

MEASURE 1.3.1 A: Required Documentation 2	Guidance	Number of Examples: 1 example	Dated Within: Analysis conducted within 5 years (data may be older)
2. Conclusions from **qualitative** analysis of data relevant to public health, which include:	The intent of this requirement is to show what has been learned from qualitative data. Data used in the analysis can include all primary data, all secondary data, or a combination of primary and secondary data. Data sources could include, for example, focus groups, town halls, interviews, or open-ended questions in surveys. Providing a transcript of raw, unanalyzed information collected from a focus group or spreadsheet of all the free-text responses of a survey would **not** meet the intent of this requirement. The actual data set(s) used in the analysis do **not** need to be provided. The health department could use reports produced by others, such as the state health department, an academic institution, or other organizations. However, data analysis developed by others must have a connection to the jurisdiction and the populations served by the health department and contain information relevant to public health. Program evaluation, customer satisfaction, or employee satisfaction do **not** meet the intent of this requirement. Data relevant to public health may include social conditions that have an impact on the health of specific populations served, for example, unemployment, poor housing, lack of transportation, high crime residential areas, poor education, poverty, or lack of accessible facilities for physical activity.		
a. The analytic process used. (If the analytic process used is not evident in the example, it could be indicated in the Documentation Form.)	**For required element a:** Analytic processes for qualitative data could be, for example, content analysis or thematic analysis. The intent of the analysis is to gain a deeper understanding of the raw data. This type of analysis can be conducted using spreadsheets and does **not** require the use of statistical applications. The analytic process may be indicated in the Documentation Form.		
b. Conclusions. At least some data used in the analysis must be specific to the population served by the health department or a subset of the jurisdiction's population.	**For required element b:** Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications for the community, drawing inferences about the relationship between different themes identified in the data, or making hypotheses about potential causes of the findings. This could be presented as part of, for example, an executive summary, a list of recommendations, a discussion or implications section of a report. **Documentation Examples** Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment.		

MEASURE 1.3.2 A:

Share and review public health findings with stakeholders and the public.

Purpose & Significance

The purpose of this measure is to assess the health department's ability to provide findings that are accessible to the intended audiences. Public health findings, as they pertain to the jurisdiction, should be shared for the purposes of translating data into action. Community members, partners, governing entities, governmental units, and others are more able to effect change if they are aware of the status of the health of the community. Sharing findings can facilitate community action for improvements to public health issues and their contributing factors.

MEASURE 1.3.2 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Materials that present key findings or provide a data visualization, which:	The intent of this requirement is that data analysis has been translated so that the information included in the materials is easily understood by the public. The materials could be, for example, an executive summary or 1-page memo that summarizes what can be learned from data analysis, an infographic, or a web portal that allows users to explore different graphs. A long, technical report would not meet the intent of this requirement. The materials could address, for example, health status, health behaviors, or social and structural determinants of heath. The examples for this requirement could relate to the examples provided in Measure 1.3.1 or could present different data findings.		
a. Reference the source of the data.	**For required element a:** The material will reference the source of the data, which could be, for example, the US Census Bureau, vital records, or a surveillance system. While not required, the health department is encouraged to incorporate data from multiple sources, datasets, or different data topics to support conclusions when developing materials. Using multiple, credible sources is one way to help preserve the public's trust in public health findings and conclusions.		
b. Include at least some data specific to the population or a subset of the jurisdiction's population served by the health department.	**For required element b:** While data may be collected or analyzed by others, the intent of this required element is that the materials will include data specific to the jurisdiction served by the health department or a subset of the jurisdiction's population. That is, the use of only state level data or data that address another jurisdiction will **not** be accepted from a local or Tribal health department; the use of only national level data or data that address another jurisdiction will **not** be accepted from a state health department. For example, a local health department could use reports produced by the state, an academic institution, or other organizations if jurisdictional data and findings are incorporated into the material.		
c. Are designed to be understandable to the public.	**For required element c:** Methods for designing the materials to be understandable could include, for example, data visualization (e.g., use of charts, graphs, or images to display data), social math (e.g., providing social context by visualizing comparisons of data or story telling using data), or use of infographics to convey scientifically based messages or terminology.		

MEASURE 1.3.2 A: Required Documentation 1	Guidance	Number of Examples	Dated Within
		2 examples	5 years
d. Are distributed. (If the distribution is not evident in the example, it may be indicated in the Documentation Form.)	**For required element d:** Distribution of the material could be targeted to a variety of audiences, including, for example, public health organizations, health care providers, employers, community service groups, local schools, labor unions, other public health stakeholders, partners, or the general public. A link to the health department's website alone, would **not** demonstrate distribution. A range of distribution methods could be used including sharing the material or a link through, for example, mailing lists, email lists, presentations, workshops, or social media postings. The method of distribution may be indicated in the Documentation Form (for example, if the health department distributed a one-page summary of findings to individuals as they enrolled in WIC benefits or at a health fair). **Documentation Examples** Materials that present public health data findings could include, for example, an infographic about health behaviors; dynamic webpage with disease clusters or trend information; environmental public health hazards 1-page report (e.g., lead or water); or data visualization on health indicators (e.g., infant mortality rates). Documentation of distribution could include, for example, a presentation discussing sharing of data findings, an email to partners informing them of the availability of findings on the health department's website, or a social media post informing followers how to access a data visualization platform.		

MEASURE 1.3.2 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		2 examples	5 years
2. Key data findings presented or discussed with external stakeholders. One example must demonstrate the presentation or discussion with the health department's governing entity or advisory board. The data used to develop key findings must include at least some data specific to the population served by the health department or a subset of the jurisdiction's population.	The intent of this requirement is for the health department to engage with stakeholders by presenting data findings to facilitate their use by others or having discussions about findings with others to gain additional insights on the interpretation or use of those data. Examples of public health findings could include information about, for example, health behaviors; disease clusters or trends (e.g., cancer or STIs); public health laboratory reports; environmental public health hazards reports (e.g., lead or water); health indicators (e.g., infant mortality rate); or social determinants of health (e.g., access to healthy food or affordable housing). Key findings may be drawn from quantitative or qualitative (or both) or from primary or secondary sources (or both). In addition to presenting or discussing with members of the governing entity or advisory board, other audiences could include, for example, community groups, other health or social service organizations, or other elected officials. Sharing findings with internal health department staff would **not** meet the intent of this requirement. The examples of presenting or discussing key data findings for this requirement could relate to the examples provided in Measure 1.3.1, Measure 1.3.2 Required Documentation 1, or could demonstrate presenting or discussing of different data findings, including those from reports or articles that were not developed by the health department.		

MEASURE 1.3.3 A:

Use data to recommend and inform public health actions.

Purpose & Significance

The purpose of this measure is to assess the health department's use of data to impact policy, processes, programs, and interventions. Public health actions should be based on the most current and relevant data available to improve the health of the population.

MEASURE 1.3.3 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
1. Data findings used to inform the development or revision of policies, processes, programs, or interventions that are designed to improve the health of the population. Documentation must identify both the data findings used and the resulting policy, process, program, or intervention.	The intent of this requirement is to demonstrate how data findings have been used to improve the health of the population. Data alone are **not** sufficient evidence for this requirement. Policies, processes, programs, or interventions that affect health department employees only do **not** meet the intent of the requirement. **Documentation Examples** Documentation could be, for example, submitted grant applications or program revisions or expansions. For example, an expansion of an existing diabetes prevention education program based on an increase in diabetes prevalence; a revised or new policy for tobacco free zones based on vaping data; a new program to build community resilience based on data about the impacts of climate change; change to the content of a health education program based on evaluation findings; or revisions to an existing surveillance process or procedure that adds a new reportable condition to those tracked by the health department based on emerging data. The example could also address discontinuing an intervention that data findings show has been ineffective. Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data were used to inform policy, processes, programs, or interventions.		

DOMAIN 2

Investigate, diagnose, and address health problems and hazards affecting the population.

Domain 2 focuses on the investigation of suspected or identified health problems or environmental public health hazards. Included are epidemiologic identification of emerging health problems, monitoring of disease, availability of public health laboratories, containment and mitigation of outbreaks, coordinated response to emergency situations, and risk communication. To sustain critical infrastructure during times of uncertainty, health departments must have plans in place for the continuity of operations, administrative preparedness, and resources for surge situations. Plans and processes should be tested to continually identify improvements to preparedness and response.

DOMAIN 2 INCLUDES **TWO** STANDARDS		
Standard 2.1:	Anticipate, prevent, and mitigate health threats through surveillance and investigation of health problems and environmental hazards.	
Standard 2.2:	Prepare for and respond to emergencies.	
FOUNDATIONAL CAPABILITY MEASURES:		
Assessment & Surveillance	**2.1.1 A:**	Maintain surveillance systems.
	2.1.3 A:	Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.
Communications	**2.2.5 A:**	Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency.
Emergency Preparedness & Response	**2.2.1 A:**	Maintain a public health emergency operations plan (EOP).
	2.2.2 A:	Ensure continuity of operations during response.
	2.2.6 A:	Maintain and implement a process for urgent 24/7 communications with response partners.
	2.2.7 A:	Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.

STANDARD 2.1

Anticipate, prevent, and mitigate health threats through surveillance and investigation of health problems and environmental hazards.

The ability to conduct surveillance and timely investigations of suspected or identified health problems is necessary to understand the extent, distribution, and severity of health threats or hazards, including detection of the source and those impacted. When public health or environmental public health hazards are investigated, problems can be recognized and rectified, thus preventing further spread of disease or illness. Collaboration with community partners provides opportunities to coordinate investigations for more effective mitigation of health issues and threats, which strengthens relationships and fosters trust.

MEASURE 2.1.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain surveillance protocols.

Purpose & Significance

The purpose of this measure is to assess the health department's process for collecting, managing, and analyzing health data for public health surveillance. Public health surveillance is the continuous, systematic collection, management, analysis, and interpretation of health-related data needed for planning, implementation, and evaluation of public health practices. Surveillance activities entail using data to predict and rapidly detect emerging health issues and threats as an early warning system for impending public health emergencies. Surveillance also provides key insight into the epidemiology of health issues and hazards by using data to understand determinants and distribution. Surveillance functions are also integral to documenting the impact of interventions; tracking progress toward specified goals; facilitating priority setting; and informing public health policy and strategies.

MEASURE 2.1.1 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 list	Current
1. Listing of surveillance systems used by the health department. The health department must provide a brief description of each surveillance system that includes what public health issue(s) or condition(s) it is monitoring, if that is not evident from the name of the system. The list and description may be included in the Documentation Form.	The intent of this requirement is to indicate what surveillance systems are used by the health department. This includes systems to which the health department reports data, as well as any systems that the health department may operate or manage. If the name of the surveillance system indicates what types of data are being monitored in the system (e.g., Vaccine Adverse Events Reporting System), it is **not** necessary to provide a description. However, if the name is an acronym or does not reference the type of data being monitored, the list or the Documentation Form will include a phrase or sentence to describe those data. Surveillance systems could monitor, for example, reportable or notifiable conditions, infectious illnesses, non-infectious illness/chronic disease, injury, environment, occupational health, maternal and child health, or syndromic surveillance. Surveillance systems could include, for example, the Food and Drug Administration's Adverse Events Reporting System (AERS), CDC's Vaccine Adverse Events Reporting System (VAERS), National Retail Data Monitor for Public Health Surveillance (NRDM), or notifiable disease or other reporting systems. Environmental health surveillance systems could include, for example, the Environmental Protection Agency's Ambient Air Quality Monitoring System or systems for ongoing collection of data about water quality, sewage, or lead hazards. This could be documented through a Table(s) of Contents or other listings such as a screenshot of a shared drive where surveillance protocols are accessed.		

MEASURE 2.1.1 A: Required Documentation 2	Guidance	Number of Examples: 2 processes or protocols, or a process or protocol that addresses 2 or more surveillance systems	Dated Within: 5 years
2. Process or protocol for public health surveillance data. For each surveillance system, the process or protocol must include:	The intent of this requirement is to assess what process(es) or protocol(s) are in place for surveillance systems to collect data in a systematic, continuous manner. While surveys such as BRFSS and NHIS provide critical information about the health of the population, that form of data collection is covered in Domain 1 and would **not** meet the intent of this requirement. If vital records data are collected by the health department as part of the surveillance system, vital records should be included in the documentation for this requirement. The requirement is to provide one process or protocol that addresses multiple surveillance systems the health department is involved in **or** two processes or protocols that each address one surveillance system. Infectious illness (or communicable disease) could include, for example, HIV, sexually transmitted infections, vector-borne diseases, vaccine-preventable diseases, enteric diseases, healthcare associated infections, Hepatitis C, or influenza and viral respiratory diseases. If the health department plays any role in a particular required element, the process or protocol will address how the health department performs its role in that element. For example, if a health department reports data into a surveillance system maintained or operated by another entity, required element a will describe how the health department reports those data. If the health department has no role in a particular required element, the process or protocol will address how another agency conducts that element.		
a. How data are reported or collected 24/7.	**For required element a:** Data could be collected from, for example, health care providers, hospitals, laboratories, or other individuals or entities in a variety of ways. Methods for 24/7 data collection could be, for example, a designated telephone line, email addresses, or ability to submit a report electronically. Reports may be received by a contractor or by a call center (e.g., a poison control center), via regional or state agreements, or other arrangement. The health department defines from whom reports are received.		
b. What data quality control measures are in place.	**For required element b:** Surveillance data quality control measures could include, for example, checking for duplication; addressing outliers in the data; or other steps used to clean the data.		
c. How data are analyzed to identify deviations from expected trends.	**For required element c:** While the process or protocol may not specify one method of data analysis used for all data analysis, it will discuss how the health department is able to identify when the surveillance data deviate from expected trends or how fluctuations are identified. Knowing when acceptable thresholds have been exceeded will allow the health department to initiate additional investigation or mitigation steps.		

MEASURE 2.1.1 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 processes or protocols, or a process or protocol that addresses 2 or more surveillance systems	**Dated Within** 5 years
d. How data are disaggregated by subpopulation.	**For required element d:** The process or protocol will discuss how the health department is able to view data specific to subpopulations. Data could be disaggregated by, for example, race, ethnicity, gender, age, other demographics, or geographic location. This can be used to identify the disproportionate impact of health conditions or environmental health hazards among subpopulations.		
e. Which surveillance data are considered to be confidential.	**For required element e:** The process or protocol for determining which surveillance data are confidential could be, for example, a set of criteria used for making this determination or a list of fields from the surveillance system.		
f. How confidential data are maintained in a secure and confidential manner.	**For required element f:** The process or protocol will include methods by which surveillance data are maintained in a secure manner, which may address, for example, physical data (e.g., storing hard copies in a locked room) or electronic data (e.g., data received via email having encryption protocols or firewalls). Other methods could include monitored user access or permissions, password protections, or computer safeguards (e.g., timed user sessions). This required element could be included in a broader protocol about data security and confidentiality, if that protocol applies to surveillance data.		
g. How the system to collect data is tested including the frequency of system tests. One of processes or protocols must be for infectious illness surveillance. If the health department plays any role in any of elements a-g, the protocol must address how the health department performs its role(s). If any of elements a-g are carried out in full by another agency, alternate documentation could be provided. (See guidance column.) If the health department has responsibility related to just one surveillance system, that will be indicated to PHAB and only one process or protocol is required.	**For required element g:** The intent of this required element is to show there is a process or protocol for testing the surveillance data collection system(s) – showing specific examples of testing would **not** be sufficient here. The process could address, for example, how tests are conducted to ensure receipt of surveillance data during or after working hours. Documentation of how other entities perform surveillance could include, for example, an MOU, MOA, copy of the law or administrative rule, or shared policy/procedure. If the state health department is carrying out the functions, the local or Tribal health department could provide the state surveillance manual or other documentation that describes how the state fulfills these functions for local jurisdictions. A Tribal surveillance system could include a diverse set of partners, including, but not limited to, federal entities, Tribal epidemiology centers, local and state health departments, or other system partners. Since many Tribal surveillance systems include multiple partners outside of the Tribe, MOUs, MOAs, or other formal written agreements may be used as documentation.		

MEASURE 2.1.2 A:

Communicate with surveillance sites.

Purpose & Significance

The purpose of this measure is to assess the health department's regular contact with sites responsible for reporting surveillance data to the health department. The health department ensures that surveillance data reporting sites are providing timely, accurate, and comprehensive data by communicating with and training them about their public health surveillance responsibilities. If this function is carried out in full by a federal agency or other health department, this measure does **not** apply.

MEASURE 2.1.2 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 process and 1 partial or full list	2 years
1. The process to maintain updated contact information for sites that provide surveillance data to the health department **and** evidence of a surveillance site list. The actual list or a screenshot of the full or partial list is required. If this function is carried out in full by a federal agency, other health department, or other entity, this must be indicated to PHAB and no documentation is needed for this requirement. If the health department maintains multiple lists or multiple processes depending on the surveillance system, documentation is only required for one system.	The intent of this requirement is to assess the health department's processes to ensure the contact information for sites reporting surveillance data is current and up to date. Maintaining current contact information allows for the effective and efficient flow of information, including information sharing with surveillance sites about their responsibilities for reporting. A regularly updated and verified list(s) supports surveillance efforts, contributes to epidemiological investigations, and encourages ongoing engagement. Examples of surveillance sites included in the list could include, for example, health care providers, schools, laboratories, veterinarians, or Tribal epidemiology centers. The process for maintaining the surveillance site list could include, for example, reviewing the list for accuracy, or updating the list if there are changes in personnel.		

MEASURE 2.1.2 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 2 years
2. Training provided to surveillance sites about the following:	The intent of this requirement is to demonstrate training provided to surveillance sites, whether the materials were developed by the health department or others. Trainings or meetings may address general surveillance requirements or disease/condition-specific requirements. Trainings or meetings could be delivered in-person, online, via webinars, or using more passive methods to share information, for example, pre-recorded videos or newsletters.		
a. Relevant reporting requirements, including how and what to report.	**For required element a:** Reporting requirements include the methods surveillance sites must use to report conditions. Methods could include submission, for example, through a surveillance system or by fax, email, or phone. The training will also address what information is required as part of the report, such as, the type of condition, dates of illness, date of laboratory confirmed diagnosis, or patient information (e.g., contact information for the health department to initiate a case investigation and contact tracing, if necessary).		
b. Reportable diseases/conditions.	**For required element b:** Reportable diseases/conditions are defined by law or rules that vary by state or territory. Reportable diseases/conditions could include notifiable diseases/conditions established by the Council of State and Territorial Epidemiologists (CSTE). The training will include what reportable diseases/conditions surveillance sites (e.g., healthcare professional, laboratories, hospitals, and other providers) are required to report.		
c. Timeframes for reporting. If this function is carried out in full by a federal agency, other health department, or other entity, this must be indicated to PHAB and **no** documentation is needed for this requirement.	**For required element c:** Timeframes for reporting refer to when the surveillance site is required to report, rather than the health department's timeframe of reporting to the state health department, CDC, or others. The timeframes for reporting may vary based on the reportable disease/condition case (e.g., surveillance sites may be required to report immediately, within 24 hours, or the next business day of suspected or laboratory confirmed diagnosis, depending on the type of reportable disease/condition). **Documentation Examples** Documentation could be, for example, training or meeting materials (such as, minutes or slides/handouts), pre-recorded videos, online training modules, emails, newsletters, or reports.		

MEASURE 2.1.2 A:	Guidance	Number of Examples	Dated Within
Required Documentation 3		2 examples	2 years
3. Surveillance data received from two different reporting sites. Each example must address a different surveillance topic. If this function is carried out in full by a federal agency, other health department, or other entity, then this must be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to show receipt capabilities, which might include from whom data were received, when and how data were received. Personal health information (PHI) will be redacted. To demonstrate different surveillance topics, the health department could provide examples from two different diseases/conditions (e.g., rabies and pertussis) or areas (e.g., vital statistics surveillance or environmental surveillance). Documentation could be, for example, reports of positive tuberculosis (TB) cases or antibiotic resistant infection received from hospitals, confirmed rabies cases reported by public health laboratories, or communicable disease reports from an assisted living facility. Screenshots of a surveillance system or registry may be used to show receipt of data entered into that system by a surveillance site.		

MEASURE 2.1.3 A:

FOUNDATIONAL CAPABILITY MEASURE

Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.

Purpose & Significance

The purpose of this measure is to assess the health department's access to laboratory, epidemiological, and environmental health services which support the rapid detection, investigation, containment, and mitigation of public health problems and environmental public health hazards. Health departments must have 24/7 access to these resources to facilitate prompt response to emergent or escalating health problems and hazards.

MEASURE 2.1.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or procedure or a set of policies or procedures that cover epidemiology and environmental resources	**Dated Within** 5 years
1. Policy(ies) or procedure(s) outlining how the health department maintains 24/7 access to resources for the detection, investigation, containment, or mitigation for both public health problems and environmental public health hazards. The policy(ies) or procedure(s) must address resources for each of the following:	Policies or procedures may be contained in the Public Health Emergency Operations Plan or may be separate policies and procedures used by the health department, such as communicable disease policies or environmental health investigation and containment procedures. The intent of this requirement is that if the health department is notified of an emergent or escalating health problem or hazard, it can access epidemiology **and** environmental resources at any time of day or any day of the week when necessary. Accessing resources could entail referring the emergent or escalating problem to another entity. Resources may be within the department, such as in-house epidemiologists, environmentalists, and sanitarians. If access to these resources is not available internally, the health department may have agreements with other agencies, individual contractors, or a combination in order to be responsive 24/7. For example, if a local health department relies on the state health department, then the policy or procedures will describe how the local health department accesses these resources or refers the emergent problem to the state health department. Resources may be within the department, such as in-house epidemiologists, environmentalists, and sanitarians. If access to these resources is not available internally, the health department may have agreements with other agencies, individual contractors, or a combination in order to be responsive 24/7. For example, if a local health department relies on the state health department, then the policy or procedures will describe how the local health department accesses these resources or refers the emergent problem to the state health department.		
a. Epidemiology.	**For required element a:** Epidemiology resources could include access to staff to support tasks related to, for example, conducting investigations, collecting and analyzing data, or creating and adjusting models to predict the spread of disease. The policy or procedure could, for example, include how a local health department accesses epidemiology resources from the state health department or be a copy of an MOU with other health departments in the region to share epidemiology resources.		
b. Environmental.	**For required element b:** Environmental resources could include, for example, environmentalists or sanitarians. The policy or procedure could describe, for example, how additional resources may be accessed when needed (e.g., chemical spill, radiation, natural disasters).		

MEASURE 2.1.3 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		Accreditation documentation, certification or licensure appropriate for all labs used by the health department for testing	Current
2. Current accreditation, certification, or licensure appropriate for **all** laboratories the health department uses for testing. Certificates must not be expired at the time of documentation submission to PHAB. There must be at least one laboratory to which the health department has 24/7 access. If the 24/7 access or type of lab testing performed by the laboratory is not included in the accreditation, certification or licensure, it must be listed on the Documentation Form. If the access to lab capacity is outside the state, local, or Tribal government, formal documentation, such as a contract or MOU, is required to be submitted with the accreditation/ certification/licensure.	The intent of this requirement is to ensure the health department has access to laboratory data to inform surveillance and response activities. If it is not evident in the documentation, certification, or licensure, the Documentation Form may be used to indicate 24/7 access to laboratory support and the type of lab testing performed. Laboratory capacity could be within the health department, through the state health department's lab, private laboratories, reference laboratories, or a combination of both internal and external support. Types of lab tests performed by public health labs could include, for example, communicable/reportable disease testing, water quality or drinking water certification testing, or rabies specimen testing. Types of accreditation, certification, and licensure for public health labs could include, for example, Clinical Laboratory Improvement Amendments (CLIA accreditation), College of American Pathologists (CAP) accreditation, EPA Drinking Water Certification, or others.		

MEASURE 2.1.3 A: **Required Documentation 3**	**Guidance**	**Number of Examples** 1 comprehensive protocol or set of protocols	**Dated Within** 5 years
3. **All** protocols for how laboratory specimens are packaged and transported 24/7 for testing both during normal business hours and outside business hours.	Protocols for handling and submitting specimens could include, for example, internal procedures, procedures defined by the laboratory, or a combination of procedures. Protocols could be contained in the Epidemiology Response Plan, infectious disease control manual, or separate companion document. Protocols could address, for example, current packaging and shipping requirements or regulations on the process for transporting specimens or samples to a confirmatory reference lab; processes for transporting infectious and potentially hazardous substances to labs that can test for biological, chemical, or radiological agents; or special directions from the lab based on what specimens are submitted.		

MEASURE 2.1.4 A:

Maintain protocols for investigation of public health issues.

Purpose & Significance

The purpose of this measure is to assess the health department's investigation protocols. Protocols outline a standardized approach to conducting timely, consistent, and thorough investigations. Protocols also clarify expectations among staff, including their roles and responsibilities associated with engaging with other entities. A standardized approach fosters transparency and ensures an in-depth investigation into the cause of public health issues for timely response so that further consequences can be prevented.

MEASURE 2.1.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 comprehensive Table of Contents of protocols or listing of protocols	**Dated Within** 5 years
1. Listing of protocols for conducting investigations of suspected or identified public health issues. Protocols must be in place to address investigation for each of the following types of public health issues:	The intent of this requirement is **not** to provide all protocols, but rather evidence that the protocols exist. This could be documented through a Table(s) of Contents or other listings such as a screenshot of a shared drive where protocols are accessed.		
a. Infectious illnesses	**For required element a:** Infectious conditions that may require investigation could include, for example, diseases like measles, rabies, tuberculosis, coronaviruses, or sexually transmitted diseases/infections, such as chlamydia, gonorrhea, syphilis, or HIV.		
b. Non-infectious illness	**For required element b:** Non-infectious illnesses could address, for example, asthma, diabetes, heart disease and stroke, or clusters of diseases (e.g., cancer).		
c. Injury	**For required element c:** Injury investigations could include, for example, occupational health hazards (e.g., industrial or workplace related), safety or unintentional injury investigations (e.g., falls, suicide, firearms or violence, or pedestrian-related). The intent is that the protocols address injury investigations in the community. Injury investigations related to employees (e.g., human resource functions, such as, workers' compensation, or needle stick incidents) would **not** meet the intent of this required element.		
d. Environment If the health department is **not** the entity with lead responsibility for one (or more) of the types listed, it must indicate which entity has lead responsibility on the Documentation Form. In those instances, it is not necessary to include the protocol in the Table of Contents or listing.	**For required element d:** Environmental investigations could relate to, for example, water quality (e.g., water sampling, drinking water contamination, or source investigations), food (e.g., foodborne illness), air quality (e.g., investigation of particulates or pollutants), chemical emissions, radiological hazards, or other environmental hazards (e.g., nuisances or solid waste).		

MEASURE 2.1.4 A: Required Documentation 2	Guidance	Number of Examples 2 protocols	Dated Within 5 years
2. Investigation protocol for illness, environmental health issue, or injury, which must include:	Protocols define a set of procedures which outline the standardized approach to investigations. For example, the investigation of foodborne illness could require responsibilities among environmental health and epidemiologists and could have implications for additional staff related to enforcement or extend beyond the health department to other agencies. Tribal health departments can use their agreement with the Indian Health Service (IHS) or any other organization or entity that performs investigations on their behalf to meet this requirement.		
a. Assignment of responsibilities for investigations among specific staff position(s) or partner agencies.	**For required element a:** The assignment may be to a specified position or positions (e.g., all environmental public health sanitarians, epi-diagnostic teams, or community health outreach staff in the health department), a named individual, or a partner agency. This could be shown, for example, in a flow chart.		
b. Public health issue-specific protocol steps which include: i. Investigation steps. ii. Defined timelines for each investigation step. iii. For reportable conditions, any applicable reporting requirements. (If not applicable, this may be indicated in the Documentation Form.) One protocol must address an infectious illness and the other **cannot** address an infectious illness, unless infectious illness is the only type of investigation that the health department has lead responsibility. In that case, the health department can provide two protocols for infectious illness.	**For required element b:** Steps in the investigation protocol define the timeframe—or a range of time—in which the investigative activity should be completed for various steps. For reportable conditions, the protocol will define, for example, what the health department needs to report to whom and in what timeline. The Documentation Form may be used to indicate if reporting requirements are not applicable to the investigation type.		

MEASURE 2.1.5 A:

Maintain protocols for containment and mitigation of public health problems and environmental public health hazards.

Purpose & Significance

The purpose of this measure is to assess the health department's protocols to contain and mitigate health problems or environmental public health hazards, as well as their consideration of social determinants of health and health inequities within containment or mitigation efforts. Health departments are responsible for acting on information concerning health problems and environmental public health hazards to contain or lessen the negative effect on population health. A standardized approach ensures clarity of assigned roles and responsibilities, timely response, and coordination to effectively address disease outbreaks and environmental hazards. Because public health problems and environmental health hazards can often exacerbate disparities within the population, it is important to be intentional about social determinants of health and inequities in containment and mitigation efforts.

MEASURE 2.1.5 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 comprehensive protocol or a set of protocols	**Dated Within** 5 years
1. Protocol or a set of protocols for the containment and mitigation of **all** legally mandated infectious illnesses **and** environmental issues. At least one protocol for infectious illness must minimally address the process for:	The intent of this requirement is for the health department to provide written protocols or procedures for how they contain or mitigate all infectious illnesses or environmental hazards. "All" infectious illnesses or environmental issues that the health department is legally mandated to contain or mitigate is based on the authorities or body of law (statutes, rules, regulations, ordinances) that set forth the health department's mandated programs or services which were provided in the health department's accreditation Application. Additional infectious illnesses and environmental issues could be included if the health department has a role in containment or mitigation but are **not** required. Protocols could address, for example, foodborne illness or lead investigations. These protocols could be in a single document or comprised of many separate documents.		
a. Case and contact management.	**For required element a:** Case and contact management could include, for example, contact tracing or post exposure notification.		
b. Exercising legal authority for disease control when thresholds are exceeded. The protocol or set of protocols must include all infectious illnesses and environmental issues the health department is mandated to contain or mitigate. Environmental hazard protocols do **not** need to address required elements a and b.	**For required element b:** Exercising legal authority could be related to, for example, containment or mitigation actions, such as, school or business closure, quarantine, isolation, allocation of MCMs, or regulation of environmental exposures.		

MEASURE 2.1.5 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
2. Consideration of social determinants of health or health inequities incorporated into containment or mitigation strategy(ies).	The intent of this requirement is to demonstrate that the health department has considered factors which contribute to higher health risks or inequities in containment or mitigation strategies in their jurisdiction. An example of an effort to assist a single individual would **not** meet the intent of this requirement. However, the health department could provide an example of an effort or strategy designed to assist, for example, a neighborhood (e.g., a community that experienced high lead levels due to old pipes) or a subpopulation (e.g., older community members if they are particularly susceptible to an outbreak or a program that provides financial assistance to low-income individuals to help replace/repair their sewage treatment systems). The example could also be a change in policies or procedures that guide future containment or mitigation efforts that take into account social determinants or health inequities (e.g., adding a social determinants of health screening in contact tracing procedures or changing policies for quarantining individuals who are in prisons or jails). The examples could be efforts or strategies developed based on actual events that required formal containment or mitigation efforts (e.g., natural disasters, pandemics) or from situations that entail more routine case and contact management (e.g., TB, or STI). The health department may or may not be the lead agency and could select a containment or mitigation effort developed in collaboration with others, such as, for example, community-based organizations (CBOs), community health workers (CHWs), or community health representatives (CHRs). Strategies could address, for example, aspects of the built environment (e.g., water quality, air pollutants, lead) or climate change in areas with high rates of poverty or historic redlining; contact tracing or STI partner notification involving individuals who are undocumented; access to safe conditions in the home, workplace, and congregate living environments (including prisons and jails) during outbreaks; isolation or quarantine for individuals who are unhoused; making sure people have access to groceries or essential supplies and are not subject to eviction during isolation or quarantine; or addressing transportation barriers, for example, to access foodbanks, access follow-up treatment, or receive emergency biologics or prophylaxis.		

MEASURE 2.1.6 A:

Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.

Purpose & Significance

The purpose of this measure is to assess the health department's working relationships with governmental and community partners needed for investigating or mitigating reportable diseases, disease outbreaks, injury, and environmental issues. Coordinating with other organizations may support faster investigations or more effective mitigation, particularly when public health issues cross jurisdictional lines. In addition, working with community partners may build trust and help reach additional community members.

MEASURE 2.1.6 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years

1. Investigation or mitigation action implemented collaboratively to address reportable condition, disease outbreak, injury, or environmental health issue.

The examples must be from two different events.

If a health department has not had an investigation or mitigation need within the five years prior to submitting documentation, they must demonstrate that they have conducted two exercises or drills of their protocol to test how it works in their setting. If only one investigation or mitigation event has occurred during the timeframe, that example must be provided, as well as one example of a drill or exercise.

The intent of this requirement is to work collaboratively on an investigation or mitigation, **not** to have another entity carry out the investigation on the health department's behalf.

Each example will demonstrate that the health department has worked with at least 1 other entity to conduct an investigation or mitigate a public health problem or environmental public health hazard. Examples could include working with community partners (e.g., schools) or working with a state, local, Tribal, or military health department on an investigation that crosses jurisdictional boundaries. Examples relating to mitigating injuries could include, for example, working with the department of transportation to reduce pedestrian deaths at a dangerous intersection or working with a local factory to reduce injuries associated with heavy machinery. Examples could also address working collaboratively with laboratories, for example, to change policies or procedures to more effectively conduct a disease outbreak investigation or mitigation effort; however, sending samples or receiving laboratory reports alone would **not** meet the intent of the requirement.

If there has not been an event within the timeframe, reports of drills or exercises will be provided. The health department is not required to be the lead agency but will have participated in the drills or exercise. For Tribal health departments that have not had an investigation need within the timeframe, drills performed by IHS or Tribal Epidemiology Centers can be used for documentation, if the health department can describe how it participated in the drills.

Documentation Examples

Documentation could include investigation reports and records, After Action Reports, meeting minutes, presentations, or news articles.

MEASURE 2.1.7 A:

Use surveillance data to guide improvements.

Purpose & Significance

The purpose of this measure is to assess the health department's ability to generate reports from its surveillance system and use surveillance data to improve its processes for timely investigation or mitigation. Surveillance data are critical to understanding current and emerging health issues, as well as the existence and extent of health disparities within the health department's jurisdiction. In order to be effective, surveillance systems require the ability to generate reports for the purposes of detecting, monitoring, or mitigating the spread of health hazards or threats. Surveillance data and related systems, as well as investigation and mitigation strategies, should be continually improved to minimize the impact of current and emerging health hazards or threats.

MEASURE 2.1.7 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples from different reportable or notifiable conditions	**Dated Within** 5 years
1. Reports generated from an infectious disease reporting system to demonstrate completeness of reporting. Reports must include:	The intent of this requirement is to demonstrate the health department's ability to generate reports that could be used, for example, in ensuring investigation of infectious conditions is occurring according to defined timelines. Both examples could be included on the same report, if the reporting system includes a log with multiple reportable or notifiable conditions. A single investigation report with details could be used for each example, if the reporting system does not contain capabilities to generate a summary of multiple investigations. Documentation could include excerpts of reports generated by others, as long as the data pertains to the jurisdiction or population served.		
a. Conditions.	**For required element a:** Conditions could include, for example, infectious diseases such as measles, rabies, tuberculosis, coronaviruses, or sexually transmitted diseases/infections, such as chlamydia, gonorrhea, syphilis, or HIV.		
b. Dates associated with investigations.	**For required element b:** Dates will include the dates associated with steps in the investigation process (e.g., incident date, referral date, lab test result date, investigation attempt date, investigation close date, or reporting condition to state/federal agency date).		
c. Investigation results. Each example must address a different reportable or notifiable condition. If the health department does not have access to pull reports from a system, an explanation must be provided which addresses the process for required elements a-c.	**For required element c:** Investigation results could indicate for example, whether the case was probable, suspect, confirmed, or not a case. Investigation results could be referred to in different terms (e.g., case status or case classification status).		

MEASURE 2.1.7 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Surveillance data used to identify differences in population groups.	The intent of this requirement is to examine surveillance data to identify patterns, trends, or disparities across the population served by the health department. Data may be disaggregated by condition (infectious or non-infectious). Data could be disaggregated by demographics, geography, or other factors (e.g., analyzing immunization rates among school aged children to identify subpopulations requiring vaccination or reviewing heart disease data by race or ethnicity). Differences in the prevalence or incidence of disease could help identify root causes or contributing factors that influence health status. For example, environmental surveillance datasets could be reviewed to consider implications related to climate change or environmental justice. **Documentation Examples** Documentation could be, for example, an excerpt of a report, which may be surveillance data (e.g., seasonal influenza or other infectious illness) included in the CHA or other epidemiology report; or meeting materials or presentations showing use of surveillance data to identify differences in population groups.		

MEASURE 2.1.7 A: Required Documentation 3	Guidance	Number of Examples 2 examples	Dated Within 5 years
3. Surveillance data used to improve surveillance system or containment or mitigation strategies.	The intent of this requirement is to demonstrate how the health department uses data from surveillance systems to inform improvements in either the surveillance system itself or in containment or mitigation strategies. Surveillance system improvements could include, for example, using data to identify which surveillance site partners are not transmitting reports through the electronic reporting system in order to improve timeliness of receiving reports; modifying surveillance system fields to capture additional data to improve data analysis; or enhancing reporting processes or capabilities. Improvements in mitigation strategies could be, for example, related to contact management processes, emergency biologics or prophylaxis, processes to exercise legal authorities, outbreak management practices, or targeted outreach to increase vaccination rates among populations with lower rates. The disaggregated surveillance data from Required Documentation 2, which identify differences in population groups, could be used to drive the improvement. Improvement efforts could be formal, such as a quality improvement project or could use less formal methods. Regardless of the improvement methodology, the examples will demonstrate how data were used to inform the improvement. If the data themselves are not included in the example, a memo may be used to provide a description of the data and how it was used.		

MEASURE 2.1.8 S:

Communicate about and support investigations at the Tribal or local level.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** capacity to coordinate with Tribal and local health departments in investigations of diseases/illnesses, environmental health issues, or occupational health hazards. When the state health department is leading an investigation, communications to the Tribal or local health department in that jurisdiction can help to assure that Tribal or local officials are aware and can coordinate with the state during the investigation by contributing jurisdictional knowledge or resources. When Tribal or local health departments are leading an investigation, the state health department can play an integral role in supporting Tribal or local health departments.

MEASURE 2.1.8 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 example	5 years
1. Communication from the state health department to the Tribal or local health department(s) when the state health department led an investigation in that jurisdiction. If the investigation spans multiple jurisdictions, the example must show how the state health department communicated with all the local and Tribal health departments affected. If there were **no** investigations led by the state health department during the 5-year time period, that must be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to show how the state health department provided communication to Tribal or local health departments while leading an investigation. This could include, for example, correspondence on the status of suspected or confirmed health hazards and the status of investigations or findings. Communication when the state is not the lead in an investigation is **not** the intent of this requirement. The state health department **cannot** use examples of communicating with program divisions within the state health department's central office. In a centralized state, the examples could be communicating with staff serving local jurisdictions or with Tribal health departments. **Documentation Examples** Documentation could include, for example, correspondence to Tribal or local health department(s) on a suspected or confirmed case(s) or outbreak(s) within their jurisdiction so that they are apprised of the investigation. Documentation could also include, for example, a completed investigation report or After Action Report (AAR) for an actual event showing interaction with Tribal or local health departments during the event.		

MEASURE 2.1.8 S:	Guidance	Number of Examples	Dated Within
Required Documentation 2		1 example	5 years
2. Support provided to be responsive to the needs of a Tribal or local health department when that Tribal or local health department was taking the lead on an investigation. If there were **no** investigations led by a local or Tribal health department in the state during the 5 year time period, that must be indicated to PHAB and **no** documentation is needed for this requirement.	Support could be provided, for example, through general guidance, advice, or protocols to Tribal or local health departments performing the investigation; or actual involvement in the investigation process by coordinating supplies or equipment or sending appropriate staff (e.g., environmentalists, epidemiologists, or other subject matter experts). The intent of this requirement is to demonstrate that the state health department was responsive to the needs of Tribal or local health departments when the Tribal or local health department led an investigation. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be support to staff serving local jurisdictions or to Tribal health departments. **Documentation Examples** Documentation could include, for example, evidence that the state health department deployed staff to a Tribal or local health department to assist with an investigation; emails or meetings showing the guidance and support the state health department provided; or After Action Reports or other debriefs of investigations, or investigation reports showing how the state health department supported Tribal or local health departments. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is **not** required. The Documentation Form could describe, for example, a request for assistance made by the Tribal or local health department on a phone call or through an email. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and that recognition of Tribal sovereignty was considered in communication or decision making.		

STANDARD 2.2
Prepare for and respond to emergencies.

Health departments play important roles in preparing for and responding to disasters, including preventing the spread of disease, protecting against environmental public health hazards, preventing injuries, and assisting communities in recovery. Emergencies include, for example, natural disasters (e.g., floods, earthquakes, and tornadoes), outbreaks and pandemics, manmade or technological disasters (e.g., bridge or building collapses, nuclear accidents, and chemical releases), and terrorism (e.g., anthrax or other biological terrorism, chemical terrorism, radiological or nuclear terrorism, or bombings). Plans for responding to emergencies are critical for preparing effective public health actions during and after the event and for building community resilience over time. State, Tribal, local, and territorial emergency response stakeholders must be prepared to coordinate and collaborate with cross-sector partners and organizations when emergencies occur.

Health departments that are currently recognized as Project Public Health Ready (PPHR), a criteria-based training and recognition program of the Centers for Disease Control and Prevention (CDC) and National Association of County & City Health Officials (NACCHO) are exempt from submitting documentation to demonstrate conformity with Standard 2.2 requirements. Rather than submitting documentation for Standard 2.2, PPHR recognized health departments may choose to submit their "Letter of Recognition" or a screenshot from the NACCHO website demonstrating current PPHR recognition. Evidence must include a date and demonstrate recognition has not expired at the time documentation is submitted to PHAB.

MEASURE 2.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain a public health emergency operations plan (EOP).

Purpose & Significance

The purpose of this measure is to assess that the public health emergency operations plan describes public health functions that are required in emergency response. Health departments play an integral role in preparing communities to respond to and recover from threats and emergencies. Preparedness plans are essential to facilitate preparedness for, response to, and recovery from public health emergencies.

MEASURE 2.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 3 years
1. The public health emergency operations plan (EOP) or the public health annex to the jurisdiction's emergency response plan. The submitted plan or annex(es) must include:	Public Health Emergency Operations Plan (EOP) guidelines may be defined for local health departments by the state health department or may be defined for both state and locals by a Federal or another state agency, such as an office of emergency management. Tribes may use guidelines that are most appropriate for their unique emergency management needs. The public health emergency operations plan may be a standalone document that delineates the health department's roles and responsibilities, or it may be a section within a larger community EOP. For example, some departments may refer to the Public Health EOP as the ESF #8. Separate annexes or attachments may be used, as needed. A public health EOP could address the needs of residents within a larger region, for example, but the submitted plan will include details that address the requirements specific to the jurisdiction applying for accreditation.		
a. A description of the purpose of the plan.	**For required element a:** The purpose of the plan could be, for example, to outline procedures for preparing for, responding to, and recovering from an emergency.		
b. The description of incident command system, including designation of staff responsibilities.	**For required element b:** Staffing plans for command positions within the public health EOP could include, for example, designation of the incident commander, finance/administration section chief, logistics section chief, operations section chief, planning section chief, and PIO. The plan could identify job titles rather than listing individuals by name. One individual (or job title) may cover multiple ICS roles.		
c. The identification of individuals who are at higher risk, which must include those with access and functional needs.	**For required element c:** The intent of this required element is to identify individuals who are at higher risk prior to an emergency. Populations at higher risk may be defined by basic access and functional need category (i.e., their ability to perform necessary functions in a disaster), which include, communication, ability to maintain their own health or self-care, independence, safety, support, self-determination, and transportation. The populations who are at higher risk may vary depending on the nature, location, or type of hazard, and may be identified based on their level or risk of exposure or susceptibility (e.g., older adults or people with disabilities). Health departments can contribute to work other agencies (e.g., emergency management) may lead by identifying specific populations with vulnerabilities, for example, populations who are low-income, unhoused, or transient; or persons without a personal vehicle, with mobility impairments, who need medical equipment in order to travel, or with limited English proficiency. Individuals who do not trust the government or medical research due to a history of mistreatment, including communities of color or indigenous communities, could also be considered.		

MEASURE 2.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 3 years
	Various approaches may be used to identify individuals who are at higher risk. For example, populations who are disproportionately affected by conditions that contribute to poorer health outcomes identified in the state/Tribal/community health assessment could be layered into a risk assessment compiled by emergency management to develop a more complete picture of who would be particularly at risk during public health emergencies. The identification of individuals who are at higher risk could be completed in collaboration with others (e.g., other governmental agencies or healthcare coalitions). The documentation could be, for example, within the EOP, a separate annex, or another attachment such as a jurisdictional risk assessment (JRA).		
d. At least two processes in place to meet the needs of individuals at higher risk (identified in required element c).	**For required element d:** Processes to meet the needs (e.g., transportation needs, translation services, special outreach to counteract historical mistrust) of individuals at higher risk may be incorporated within the emergency operations plan or separate plan, such as, a Communication, Maintaining Health, Independence, Support/Services, and Transportation (CMIST) profile or Access and Functional Needs (AFN) plan.		
e. The lead role agency(ies), as well as the responsibilities of the health department (if any) specific to the following areas: i. Medical countermeasures ii. Mass care iii. Mass fatality management iv. Mental/behavioral health v. Non-pharmaceutical interventions, including legal authority to isolate, quarantine, and, as appropriate institute social distancing vi. Responder safety and health	**For required element e:** The Documentation Form contains a table in which the health department will indicate for each of the seven areas listed which agency(ies) is designated as the lead agency, whether it is the health department or an emergency response partner (e.g., hospitals and health care providers, emergency management agency, American Red Cross, mortuary, or coroners). The health department will also use the Documentation Form table to indicate page numbers where the health department's responsibilities (if any) for each of those seven areas are described within the emergency operations plan, annex(es), or attachment(s). If the emergency management agency (EMA)—sometimes referred to as the office of emergency management (OEM) or emergency management office (EMO)—is the lead agency for either carrying out the function or designating a lead agency based on the specific emergency, that can be indicated in the Documentation Form for each area where it applies.		

MEASURE 2.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 3 years
vii. Volunteer management (Lead role agency(ies) and page numbers, as appropriate, will be indicated on the Documentation Form.)			
f. the process of declaring a public health emergency.	**For required element f:** The process to declare a public health emergency could include, for example, what authorities are needed or the steps needed to officially make an emergency declaration. This could include the steps (formal or informal) the health department would take, as well as formal steps other entities take to declare a public health emergency. Process steps that are not formally documented may be described in the Documentation Form.		
g. Activation of public health emergency operations, including levels of activation based on triggers or circumstances.	**For required element g:** Levels of activation are based on triggers or circumstances. These may be identified in communication with the incident commander or unified command based on the jurisdiction's risk analysis.		
h. The process for collaborative review and revision of the plan. The public health EOP must cover the entire jurisdiction served by the health department or multiple EOPs must be provided to cover the entire jurisdiction.	**For required element h:** The process will show how the plan is reviewed and how revisions are considered, in collaboration with stakeholders. The review process could describe how the jurisdiction determines if there are appropriate revisions based on, for example, learnings from drills, exercises, or actual events in the jurisdiction; updates to guidance from the CDC (e.g., PHEP requirements) or other national, state, or regional entities; current risk assessments; or changes in the population or the risk factors in the jurisdiction (e.g., adding provisions to address fires if that risk increases or including outreach in additional languages or using community health workers, community health representatives, or others to better reach subpopulations).		

MEASURE 2.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Ensure continuity of operations during response.

Purpose & Significance

The purpose of this measure is to assess plans to ensure continuity of operations during a response. This ensures that health departments are able to maintain services that are considered essential during an emergency.

MEASURE 2.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. Continuity of operations plan, which must include:	The continuity of operations plan (COOP) describes the health department's preparations to continue essential functions during a wide range of emergencies, including localized acts of nature, accidents, pandemic, technological, and attack-related emergencies. Continuity of operations guidelines may be defined by a federal or state agency, such as an office of emergency management. Tribes may use guidelines that are most appropriate for their unique emergency management needs.		
a. Identification of essential public health functions that must be sustained during a continuity event.	**For required element a:** The health department will identify what public health functions or services must be maintained without prolonged interruption (as defined by the health department). Those functions may vary by jurisdiction and could include, for example, vital statistics, surveillance systems, laboratory services, human resources, or business functions. If the essential public health functions vary based on the nature or the duration of the event, the plan could describe how the health department determines what is considered essential.		
b. Orders of succession.	**For required element b:** Orders of succession include delegation of authority if leadership is unavailable to perform legally authorized or critical roles and responsibilities. Identifying multiple individuals (or job titles) in the order of succession allows for contingency planning, particularly in the context of a lengthy emergency. The orders could also include qualified individuals to serve in key positions, such as administrators, directors, and key managers, as well as defined roles and responsibilities.		
c. Identification of an alternate location for key health department staff to report, if necessary, or the ability to work virtually.	**For required element c:** The plan will indicate alternate locations or if work can be performed virtually. The alternate facility(ies) could consider alternate uses of existing facilities or the relocation of a limited number of key leaders or staff to another location where the potential for disruption of the organization's ability to initiate or sustain operations is minimized. The plan could also address conditions in which staff could work remotely, such as protocols that describe remote work processes (e.g., equipment and supplies, methods of sharing protected information, or capability to hold virtual meetings).		

MEASURE 2.2.3 A:

Maintain and expedite access to personnel and infrastructure for surge capacity.

Purpose & Significance

The purpose of this measure is to assess the health department's ability to access necessary equipment and engage personnel for surge, as well as to expedite administrative processes during a response. Access to personnel, requisite infrastructure, and laboratory services is critical when the capacity for response to an emergency exceeds normal health department capacity.

Administrative preparedness ensures fiscal, legal, and administrative practices are in place to ensure continuity of operations and remove barriers that can prevent timely response during an emergency. Plans and processes that govern funding, procurement, contracting, and hiring require appropriate integration into all stages of emergency preparedness and response. A lack of administrative preparedness planning may have detrimental consequences during an emergency, such as, a delay in the acquisition of essential goods, resources, services, or in the hiring, assignment or reassignment of response personnel. Administrative preparedness might also consider the disposition of emergency funds and legal determinations needed to implement protective health measures.

MEASURE 2.2.3 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 inventory	5 years
1. Inventory or other documentation which details types of equipment or other infrastructure necessary for responding to an emergency that exceeds the health department's capacity and how those resources are accessed. The inventory or other documentation may include resources the health department has readily available but must include the health department's access to material resources outside of what is available to them during non-surge situations.	The intent of this requirement is that the health department has access to, and has inventoried, additional equipment or infrastructure (e.g., transportation, communications, software for volunteer management, or PPE) available to the department in surge situations. Equipment available for surge could include, for example, modes of transportation like trucks, vans, or trailers; heavy machinery; radios or walkie talkies; laptops; personal protective equipment like face masks or goggles; or tables and chairs. The health department could also include resources for additional infrastructure such as use of physical spaces like auditoriums or gymnasiums. The health department will indicate how it accesses the equipment by either describing where the equipment is located or if it is available through a MOU or mutual aid agreement. **Documentation Examples** Documentation could include, for example, lists, spreadsheets, screenshots of electronic inventory databases.		

MEASURE 2.2.3 A: Required Documentation 2	Guidance	Number of Examples 1 comprehensive protocol, or set of protocols	Dated Within 5 years
2. Protocols for engaging personnel in a surge scenario, that must minimally include the following:	The intent of this requirement is that the health department has proactively identified what positions will be required in a surge response, and how surge roles will be filled. Identifying personnel for surge capacity could include additional roles beyond laboratory, epidemiological, and environmental personnel, such as nurses, health educators, disease investigators, communications specialists or PIO support, logistics or information technology support, or administrative personnel. The protocol could include external surge personnel, such as Medical Reserve Corps, Epi-Aid, students, or other volunteers, in addition to paid staff. The protocol could be contained in the public health EOP, be part of a different plan or protocol, or included in an MOU or agreement with another entity to provide surge. If the health department operates a public health laboratory, it will include laboratory personnel within the protocol (required elements a-d). If the health department does not operate a laboratory, it will indicate that in the Documentation Form.		
a. How the health department manages the list of who it can contact for surge staffing, including a list of any entity with whom it has an MOU for surge personnel.	**For required element a:** The health department will describe its process for how it maintains a list of surge personnel. If surge personnel are available through MOUs or mutual aid agreements, the protocol will list those agreements. If the health department maintains a list of specific personnel who are available for surge, the process could include, for example, how the health department periodically reviews the list to ensure contact information is current.		
b. How surge personnel are notified.	**For required element b:** Surge personnel could be notified, for example, through an alert or notification system or by phone or email.		
c. How personnel are informed of their roles and responsibilities for the surge scenario.	**For required element c:** Personnel could be informed of their roles and responsibilities during a briefing, for example, which might address pertinent information such as the current status of the emergency, how the volunteer is to operate within incident management, job action sheets, or roles and responsibilities assigned based on necessary skills, knowledge, and credentials as applicable. The protocols could also address how roles and responsibilities for spontaneous volunteers (i.e., those who request to be part of supporting response efforts) are triaged and incorporated with other volunteer resources.		

MEASURE 2.2.3 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		1 comprehensive protocol, or set of protocols	5 years
d. How the health department addresses the safety of personnel during a surge scenario. The protocol must minimally include laboratory (if the health department operates a public health laboratory), epidemiological, and environmental personnel. If the health department does not operate public a health laboratory, it can be indicated on the Documentation Form.	**For required element d:** Safety considerations for surge personnel could consider, for example, medical, environmental exposure, or mental or behavioral health risks responders might encounter. Protocols could address, for example, establishing a rotation schedule among staff to alleviate burnout; designating a safety officer or subject matter experts to provide health and safety recommendations; distributing safety materials (e.g., basic or risk-related personal protective equipment); providing training among surge personnel on proper use of safety equipment; or establishing processes for area providers to provide medical, mental, or behavioral health care for surge personnel.		

MEASURE 2.2.3 A: Required Documentation 3	Guidance	Number of Examples	Dated Within
		1 process or set of processes	5 years
3. The process(es) for expedited administrative procedures used during a response to an event for **all** of the following:	The intent of this requirement is to ensure the health department has an established process(es) to access funding, workforce, and other forms of assistance in an expedited manner during an emergency. To facilitate rapid response, these processes typically differ from standard or non-emergency procedures. Documentation of one specific instance when a health department expedited a contract, for example, would **not** meet the intent of the requirement. The process(es) could take several forms, including, for example: ▪ A separate formal policy or plan on expediting administrative procedures. ▪ Part of the Continuity of Operations Plan (COOP). ▪ Less formal documentation, such as, a presentation or memo between other governmental entities, to describe the health department's process for how it works with other governmental entities (e.g., the state health department, budget office, county council) to expedite administrative procedures. If the health department has limited authority to implement expedited administrative procedures, the process may describe the approach used to engage those who do have authority (e.g., city council, or county commissioners) or the specific steps the health department has taken to make efforts to expedite each of these processes.		

MEASURE 2.2.3 A: Required Documentation 3	Guidance	Number of Examples 1 process or set of processes	Dated Within 5 years
	▪ Policies or procedures that have been revised to minimize delays in administrative procedures that were originally designed for response events that are now considered routine procedures can be provided with a description of how the change expedited processes.		
a. Accepting, allocating, or spending funds.	**For required element a:** The process could address, for example, expedited acceptance of emergency preparedness funding for immediate use, establishment of an emergency fund, or expedited financial approval processes. The state health department could, for example, consider processes for expediting the immediate use of funds among local or Tribal health departments (e.g., eliminating grant applications or award restrictions). Examples of flexibility to expedite spending funds could include, for example, removing retroactive reimbursement mechanisms, removing or reducing spending restrictions, granting no-cost extensions or continuation awards.		
b. Managing or hiring the workforce.	**For required element b:** The process could include steps to expedite or make more flexible, for example, hiring, reassignment of staff, use of volunteers for surge (e.g., the Medical Reserve Corps, CDC Foundation, or EIS/EpiAid deployments), or practices for contract workers or hourly employees. The process could also address, for example, building a volunteer database, reducing qualifications, or expediting background or credentialing verification processes.		
c. Contracting or procuring mutual aid.	**For required element c:** The health department could expedite contracting or procurement of mutual aid related to, for example, procurement of supplies or transportation; purchase order practices (e.g., relationships formed with supply companies to acquire medical supplies, including PPE or other equipment or facilities); Emergency Management Assistance Compact (EMAC); or mutual aid agreements or other agreements (e.g., with local organizations or healthcare coalitions).		

MEASURE 2.2.4 A:

Ensure training for personnel engaged in response.

Purpose & Significance

The purpose of this measure is to assess the health department's ability to provide necessary training to staff who are engaged in response activities. This includes both training that is planned in advance so that staff are prepared to operate using incident command, as well as just-in-time training that is responsive to the needs of the particular emergency.

MEASURE 2.2.4 A **Required Documentation 1**	**Guidance**	**Number of Examples** 1 training schedule	**Dated Within** 5 years
1. A schedule for training or exercises to prepare personnel who will serve in a response capacity, which includes at a minimum basic FEMA trainings on incident command. This must include surge personnel as well as personnel for whom response is part of their normal job responsibilities. Preparedness does **not** have to be the sole focus of the trainings or exercises but must be an identifiable component of the trainings.	The training schedule may be part of the public health EOP, the Multi-Year Training and Exercise Plan, the health department's workforce development plan, or may be a standalone schedule of training and/or exercises. As of the publication of The Standards, minimum training includes FEMA IS 100, 700 and 800 training. The schedule will identify the expectations of when personnel will participate in trainings (e.g., upon hire, Quarter 1, or within a month of being identified as surge personnel). Proof of completed training is not required but documentation will reflect that the schedule has been reviewed within the last 5 years. While all personnel who will serve in a response role, including surge personnel, require basic training, additional or position-specific training, as appropriate, may also be included in the training schedule. In addition to ICS, the schedule may include additional or refresher FEMA courses, NIMS training, or other topics, such as, fit testing for N95 masks or use of other personal protective equipment, POD training, an overview of the Strategic National Stockpile (SNS), or surge-position specific training for those identified as surge personnel. Additional training needs, such as cultural humility, could also be identified and included within the training schedule. **Documentation Examples** Documentation could be, for example, an excerpt of the public health EOP or workforce development plan, a spreadsheet, or other schedule of trainings or exercises.		

MEASURE 2.2.4 A **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example or process	**Dated Within** 5 years
2. Proactive or just-in-time training for individuals involved in response activities. If no proactive or just-in-time trainings have been conducted within the last 5 years, a process of how just-in-time trainings would be provided, must be submitted.	The intent is **not** to provide a routine training (as addressed in the training schedule topics from Required Documentation 1), **but instead** to demonstrate proactive or "just-in-time" training that provides immediate instruction or information to responders (e.g., key personnel or volunteers). The content could include, for example, specific roles and responsibilities (e.g., job aids or position or function specific duties), deployment resources (e.g., checklists, tools, or other templates), or the latest information on the current status of the situation. If it is not evident from the example, the documentation could be supplemented with an description in the Documentation Form about the emergency or event to provide context for why the proactive or just-in-time training was held. **Documentation Examples** Documentation could include, for example, training materials, recorded webinars, written training, or deployment resources provided to responders. If no proactive or just-in-time trainings were conducted in the previous 5 years, the documentation will be a process for how just-in-time training would be delivered.		

MEASURE 2.2.5 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency.

Purpose & Significance

The purpose of this measure is to assess the health department's plans for, and implementation of, risk communications during a crisis, disaster, outbreak, or other threat to the public's health. A risk communications plan outlines the health department's approach to providing information to the public about actual and perceived health risks, the current status of the situation, and actions that should or should not be taken by the public to address their needs and concerns. Accurate and timely information—and efforts to dispel misinformation—are critical to influencing behavior and protecting the population's health.

MEASURE 2.2.5 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
1. A risk communication plan that:	The risk communication plan outlines the methods to provide accurate, timely, effective communications during an emergency. There is no required format for the plan. It could be part of an overall department emergency operations plan. The health department may provide a communication plan that includes both non-emergency and emergency communications, as long as the plan delineates which processes are used for routine communications, emergency situations, or both. A risk communication plan may be also be termed, for example, as an emergency communication plan or crisis communication plan or policy. Health departments may provide a written MOU or MOA with an external agency to perform risk communications on behalf of, or in collaboration with the health department. For example, a Tribal health department can provide an agreement with an external agency, such as a local health department, with clearly delineated roles for Tribal and non-Tribal staff and elected officials involved in the plan. For Tribal health departments, documentation could reference an existing, approved Tribal policy that identifies another Tribal employee or program (e.g., the Tribal emergency management planner) as being responsible for the risk communication plan and its implementation. In these instances, the health department may provide the risk communication plan or procedures of the external agency showing how required elements a-i are performed.		
a. Describes the process used to develop accurate and timely messages.	**For required element a:** To ensure messages are accurate, the plan could include, for example, provisions for a review of communications by experts or a process for fact checking. Part of ensuring accuracy is making sure that the health department is not omitting data that provide important context and is being transparent about how data may be updated or change over time. To ensure messages are timely, the plan could, for example, include guidance about target timeframes for responding to information requests or flow charts for content review with target timeframes. Because conditions and scientific understanding can change rapidly during an emergency, the plan may include provisions about how the health department regularly revisits previously released statements and informational materials to update them as new information emerges. The plan might also describe resources the health department uses in developing messages, such as the CDC's Crisis and Emergency Risk Communication tools.		

MEASURE 2.2.5 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
b. Describes methods to communicate necessary information to the entire community, including subpopulations who are at higher risk.	**For required element b:** Methods of communications will vary based on the community and could include, for example, the use of visuals or materials written in plain language. The entire community includes subpopulations and individuals who are at higher risk, which may be identified, for example, in a Communication, Maintaining Health, Independence, Services and Support, Transportation (CMIST) profile or Access and Functional Needs (AFN) plan. Subpopulations or at-risk individuals could include, for example, children, older adults, or pregnant women, as well as individuals who may need additional response assistance, such as individuals with disabilities, who live in institutional settings, from diverse cultures, who have limited English proficiency or are non-English speaking, with low literacy, who are transportation disadvantaged, who have chronic medical disorders, who have pharmacological or substance dependency, or are transient (e.g., individuals who are unhoused or migrant farm workers). Individuals who do not trust the government or medical research due to a history of mistreatment might also be considered.		
c. Addresses misconceptions or misinformation.	**For required element c:** Addressing misconceptions or misinformation can help prevent public alarm. Methods could include, for example, proactively engaging with the public to correct misinformation, using technology or social media platforms to share accurate information from reputable sources, using social math (designed to make statistics and other data more understandable to the audience) or infographics to convey scientific messages or terminology, or developing localized messaging in collaboration with community groups, members, or local organizations. Using multiple, credible sources is one way to help preserve the public's trust in public health messages.		
d. Describes the process to expedite approval of messages to the public during an emergency.	**For required element d:** Expediting approval of messages could include, for example, establishing a process to clear information simultaneously (e.g., gathering subject matter experts, public information officers, and other decision-makers together at once to expedite the approval process), developing mechanisms to conduct a courtesy check with other response partners for message consistency, prioritizing messages on a "need to know" versus "want to know" basis, developing a strategy for message clearance that identifies key subject matter experts who are available to review messages for accuracy or policy advisors to ensure information is consistent with policies or laws, or developing a strategy to rapidly disseminate communication through web, social media, or media outlets. The approval process may also be part of the incident command system deployed in the community.		

MEASURE 2.2.5 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
e. Describes how information will be disseminated in the case of communication technology disruption.	**For required element e:** Methods in case of technology disruption could include, for example, radios or radio public service announcements, internet connections that use cellular data instead of wi-fi (e.g., air cards, tablets, cell phones), megaphones, door-to-door communication, or printed materials.		
f. Describes the process for managing and responding to inquiries from the public during an emergency.	**For required element f:** Methods for managing and responding to inquiries from the public could include, for example, operating call centers, managing and responding to inquiries on social media or websites, or monitoring and responding to questions or topics raised by the public through the media, in person, or other channels.		
g. Describes the process to coordinate the communications and development of messages among partners during an emergency.	**For required element g:** Methods could include, for example, steps taken to ensure messaging with partners is complementary and not contradictory, or a process to coordinate collective communications in order to reach intended target audiences.		
h. Contains a list with media contact information.	**For required element h:** The list could include contact information related to, for example, television, radio, newspaper, or other forms of conveying information to the public in the community (e.g., websites that are commonly considered as a source of local news). Restricted information may be redacted from the contact list.		
i. Describes the procedure for keeping the media contact list current and accurate.	**For required element i:** The procedure could outline, for example, the frequency, staff member responsible, and elements of the media contact list that are reviewed and updated.		

MEASURE 2.2.5 A:

Required Documentation 2

2. Communication with the public during an emergency.

One example must demonstrate how the department worked with the news media to disseminate information during a public health emergency.

The other example must demonstrate use of social media.

One of the two examples must show how the department utilized a strategy specifically focused on communicating with a population that requires special communication considerations.

If no emergencies have occurred within the last 5 years, the health department must indicate that to PHAB and **no** documentation is needed for Required Documentation 2.

Guidance

Number of Examples
2 examples; 1 with news media and 1 with social media

Dated Within
5 years

The intent of this requirement is to demonstrate multiple methods of communicating with the public during an emergency.

The health department could demonstrate working with the news media through, for example, press conferences or interviews (radio or television), media packets, publication of a press release, or public service announcement. Use of social media could include, for example, posts to Facebook, Twitter, or other platforms.

Special considerations could address, for example, linguistic appropriateness, including both the language(s) used to communicate a message as well as tailoring messaging to address considerations such as health literacy. Other methods could consider people with disabilities (e.g., using sign language interpreters) or people with behavioral health or substance use disorders. Other considerations might address cultural humility, which considers the way people view, experience, and make choices about their health based on multiple factors (e.g., religion, economic and educational factors, cultural values, beliefs, customs, and ways of living). Health departments could demonstrate working closely with individuals and organizations who are considered trusted messengers for their communities (e.g., community and religious leaders, school leaders, local elected officials, or heads of cultural organizations) to support bi-directional information sharing. The documentation could be supplemented with an explanation in the Documentation Form to indicate how the example shows the department focused on communicating with a population that requires special communication considerations.

The examples could be from an emergency that activated the public health EOP, but they do **not** need to be. They could also be from, for example, a flu outbreak in a nursing home that did not cause the EOP to be activated.

Documentation Examples

Documentation could be press releases, television or radio interviews, or tweets.

MEASURE 2.2.6 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain and implement a process for urgent 24/7 communications with response partners.

Purpose & Significance

The purpose of this measure is to assess the health department's protocols for, and implementation of, communications with response partners during emergencies that may occur within or outside normal business hours. This includes the health department's ability to receive and issue health alerts and to communicate and coordinate with appropriate public health response partners on a 24/7 basis.

MEASURE 2.2.6 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 protocol, process, or system	**Dated Within** 5 years
1. An emergency communication protocol, process, or system for contacting response partners 24/7 during a public health emergency, which must include:	The intent of this requirement is that the health department has a protocol, process, or system for contacting key response partners when an urgent public health issue arises and on a 24/7 basis. This requirement may be—but does **not** need to be—addressed through a Health Alert Network (HAN). A HAN usually has the capacity to issue and receive response messages or information related to a public health problem, using multiple contact points in case of technology disruption. Alternatively, if a HAN system is not in place, other communication methods may be used to show rapid dissemination of alerts and information through contact points, such as, phone, email, or text message. The HAN may be a state system in which Tribal or local health departments participate. The Tribal or local system may establish a smaller system for providers and responders within the jurisdiction of the health department. Some jurisdictions have established a Joint Information Center (JIC) with a public information officer for the health department; health departments may provide evidence of this as documentation.		
a. A list of response partners that minimally includes health care providers, emergency management, emergency responders, and environmental health agencies.	**For required element a:** Partner refers to the broad categorization of response partners that require communication capability with the health department during potential or actual incidents of public health significance, or any agency with which the health department might work or communicate during an emergency in an effort to meet the health needs of the population in a jurisdiction. The list will include health care providers (e.g., hospitals, FQHCs, primary care providers), emergency management, emergency responders (e.g., EMS, fire, police), and environmental health agencies. In addition, the list could include, for example, social service providers, pharmacies, mental health organizations, volunteer organizations, universities, the media, and neighboring health districts. Partners exist at the local, state, Tribal, and federal levels. Response partners could also include organizations capable of developing or translating and disseminating alerts and information to individuals with disabilities, who do not speak English, or who require particular communication considerations.		
b. A description of how alerts are sent and received 24/7.	**For required element b:** If a series of screenshots is used to show the system, the documentation could be supplemented with a description in the Documentation Form of how alerts are both sent and received on a 24/7 basis.		

MEASURE 2.2.6 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
2. Evidence that the protocol, process, or system for sending an alert to emergency response partners (provided in Required Documentation 1) has been used or tested. One example must demonstrate use of the protocol, process, or system outside of normal business hours.	The intent of this requirement is that the health department has implemented the protocol, process, or system provided in Required Documentation 1 to send or issue alerts. Examples could be of either a test or an actual alert. Documentation does **not** need to demonstrate that all means of contact are tested or use of different systems. Both examples could demonstrate issuing an alert through a HAN. **Documentation Examples** Documentation could include, for example, screenshots, emails, reports or queries from the HAN, or other records of testing or using the protocol for contacting emergency response partners.		

MEASURE 2.2.7 A:

FOUNDATIONAL CAPABILITY MEASURE

Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to improve preparedness and response through planned exercises and development of descriptions and analysis of performance after an emergency operation or exercise (After Action Reports). Effective improvement planning serves as an important tool throughout the integrated preparedness cycle. After Action Reports provide a way for the health department to assess its performance during an emergency operation for quality improvement. It identifies issues that need to be addressed and includes recommendations for corrective actions for future emergencies and disasters. Actions identified during improvement planning help strengthen a jurisdiction's capability to plan, equip, train, and exercise. Effective preparedness planning uses a progressive approach to continually adjust and incorporate learnings to reflect changes in preparedness based on exercises or real-world experiences.

MEASURE 2.2.7 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
1. A plan for conducting response exercises, which indicates how the elements in the EOP or annexes have been or will be tested.	The plan could be, for example, the schedule of drills or exercises (e.g., the HSEEP schedule), that identifies the purpose or objectives of scheduled drills with regard to EOP elements or annexes. The plan could address response exercises in which the health department is the lead or a participant (e.g., participation in regional or state exercises). It can be specific to public health (ESF 8) or broader to address other elements or annexes of the jurisdiction's EOP. Documentation could be, for example, a list or schedule of response exercises that indicates how each will test elements of the EOP or annexes.		

MEASURE 2.2.7 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. After Action Report (AAR), which includes:	The format of the AAR is not prescribed by PHAB, as long as required elements a-e are included. The AARs may be from drills/exercises or real events.		
a. Name of event or exercise.	**For required element a:** Provide the name of the event or exercise, which might relate to the scenario or event.		
b. Overview of the event or exercise.	**For required element b:** The overview will provide a description of the event or exercise that could include, for example, the scenario, scope, focus areas (prevention, protection, mitigation, response, or recovery), and capabilities or objectives tested.		
c. Response partners involved.	**For required element c:** Partners or participants could include, for example, federal, state, local, or Tribal entities; non-governmental organizations (NGOs); and/or international agencies. If Tribal health departments have not participated in drills/exercises or real events, the health department may provide evidence showing invitations to participate.		
d. Notable strengths.	**For required element d:** Strengths might relate to capabilities or objectives tested, or other findings identified in the AAR based on the drill/exercise or real event. A "strength" is an observed action, behavior, procedure, or practice that is worthy of special notice and recognition so that it can be sustained or built upon in the future.		

MEASURE 2.2.7 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
e. Listing and timetable for improvement(s). At least one of the AARs must show collaboration with other health departments (state, Tribal, or local) working together on an exercise or response. One example must include a Tribe, if one exists in the health department's jurisdiction.	**For required element e:** Improvements could be where, for example, it was observed that a necessary procedure was not performed; an activity was performed, but with notable problems; or there were some subpopulations that were disproportionately affected in a negative way. Improvements could also expand on the identified strengths. Improvements could be, for example, related to objectives or capabilities tested and performed with challenges, or could more broadly address revisions needed to the EOP, the planned approach to exercises, training, or administrative functions related to preparedness. The health department and its partners determine the timetable for improvements.		

MEASURE 2.2.7 A: Required Documentation 3	Guidance	Number of Examples 2 examples	Dated Within 5 years
3. Improvements made based on AARs provided in Required Documentation 2.	Both examples can be from the same AAR or different AARs based on exercises or real events. Improvements could be related to protocols, systems, training, or equipment; adoption of new technology, standards, or best practices; or the process for exercises, training, or administrative planning. The intent of this requirement is to show that a change has been made based on the AAR. It is **not** sufficient to provide an example of a planned changed. If the linkage to the AAR is unclear, an explanation of how an AAR informed the change could be described in the Documentation Form. Documentation could be, for example, a new training that was provided based on an improvement identified in the AAR or a revision that was incorporated into the EOP as identified by the AAR.		

MEASURE 2.2.8 S:

Provide communications and other support to Tribal and local health departments related to response efforts.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in the state in preparing for and responding to emergencies. State health departments provide critical support to Tribal and local health departments by providing guidance and information to ensure effective response. Tribal and local health departments are partners in providing a public health response to an emergency. State health departments will share information concerning the state's key policies or actions during the emergency to ensure optimal coordination. State health departments may also be in a position to share communications and information received from the federal level.

MEASURE 2.2.8 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 example	5 years

1. Information sought or reviewed to understand the needs of multiple Tribal or local health departments regarding developing, revising, or testing emergency operations plans.

The example must include seeking or reviewing information about at least one Tribal health department and one local health department.

If there is not a Tribal health department in the state this must be indicated in the Documentation Form.

The intent of this requirement is for the state health department to develop an understanding about what might support Tribal and local health departments in emergency operations planning. An example about just one health department would **not** meet the intent of this requirement. If, for example, the state health department is gathering information through phone calls with individual health departments, the documentation could show notes from two phone calls with different health departments.

Seeking information could include, for example, efforts by the state to ask Tribal and local health departments about technical assistance needs or suggestions through a survey, phone call, or meeting. If the state health department can document that it asked for feedback, it is **not** necessary to demonstrate that feedback was received.

Other examples of gathering or seeking information could include, for example, reviewing requests or questions that the state health department received from local or Tribal health departments, or reviewing existing sources of information on common barriers faced by Tribal and local health departments in the development, revision, or testing of emergency operations plans (e.g., AAR from a joint exercise).

The state health department **cannot** use examples of seeking information about program divisions within the state health department's central office and their needs. In a centralized state, the examples could be information from or about the staff serving local jurisdictions or Tribal health departments.

Documentation Examples

Documentation of seeking information could be, for example, emails, phone call minutes, newsletters, memos, meeting minutes, notes from conversations (e.g., Council or Nations leadership meetings), or results of a survey with questions designed to understand the needs among Tribal and local health departments. If the health department uses an existing source of information, the documentation could be supplemented with an explanation in the Documentation Form about how this information was reviewed.

MEASURE 2.2.8 S: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Support provided to Tribal or local health departments to be responsive to their needs in developing, revising, or testing emergency operations plans. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state, this must be indicated in the Documentation Form and two examples with local health departments must be provided.	The state health department will document that it has provided support related to response planning. Support could be provided through the provision of information, discussion, or guidance through, for example, webinars, emails, briefing papers, meeting minutes, distributed sample protocols, newsletters, trainings, fax blasts, or conference calls. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be support to staff serving local jurisdictions or to Tribal health departments. Examples could be related to the activities described in Required Documentation 1, but they do **not** need to be. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and recognition of Tribal sovereignty was considered in communication or decision making. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is not required. The Documentation Form could describe, for example, a suggestion made by the Tribal or local health department on a phone call, in a meeting, or through an email. **Documentation Examples** Documentation could be, for example, newsletters, memos, meeting minutes, presentations at conferences or webinars, phone call minutes, or other documentation showing support provided in developing, revising, or testing emergency operations plans.		

MEASURE 2.2.8 S: **Required Documentation 3**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
3. Systematic communications used to ensure all Tribal and local health departments are aware of policies or actions affecting their jurisdictions taken by the state health department during an emergency. If no emergencies have occurred within the last 5 years, documentation could be from a drill or exercise to test communications.	The intent of this requirement is to describe the steps the state health department took to ensure all Tribal and local health departments within the state health department's jurisdiction were informed during an emergency about key policies or actions the state has taken that affect their jurisdictions. The nature of the policies or actions will determine which Tribal and local health departments are part of the communications. For example, if a natural disaster affects only one region of the state, the communications may be limited to those jurisdictions. However, if the policies or actions are state-wide, communication will extend to all health departments within the state health department's jurisdiction. Methods for systematic communications could include, for example, daily or weekly meetings with representatives from all health departments in the state, an intranet that includes the most recent resources, policies or procedures to ensure that local and Tribal health departments were made aware of any state-level orders or policies before they were released to the public, inclusion of representatives from Tribe(s) in the state's operations center, or a liaison between Tribal and state jurisdictional operations centers. Documentation could be, for example, in a summary report, AAR, or memo. If appropriate, the documentation could be supplemented by a description in the Documentation Form—for example, the documentation may show one agenda from a series of calls and the Documentation Form could describe how that communications method was implemented systematically.		

DOMAIN 3

Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.

Domain 3 focuses on the health department's communications, which include providing information and education to encourage healthy actions. Effective communication is essential to provide timely, accurate, and reliable information about how to protect, promote, and influence community members towards healthy actions. Health departments provide critical health education and promotion information on a wide variety of topics, including healthy behaviors (e.g., good nutrition, hand washing, and seat belt use) and health risks (e.g., the incidence or prevalence of existing and emerging health threats, such as, food borne illness, anthrax, or coronavirus). To be effective in influencing healthy actions, health departments require communication procedures that consider sound evidence, engagement with community members during the design of messages, and methods of dissemination to ensure community members are reached with actionable and understandable information. Messages need to be designed to foster trust and transparency, considering social, cultural, and linguistic appropriateness. In turn, effective communication builds an understanding among community members about the value, purpose, programs, services and importance of public health.

To facilitate bidirectional flow of information, communication strategies require continually strengthening relationships with partners and community members, including subgroups of the population served. Communication requires authentic community engagement in dialogue with the target audiences to assure that messages are designed considering cultural humility and use channels, such as social media, which are capable of rapidly reaching large audiences.

DOMAIN 3 INCLUDES **TWO** STANDARDS		
Standard 3.1:	Provide information on public health issues and public health functions through multiple methods to a variety of audiences.	
Standard 3.2:	Use health communication strategies to support prevention, health, and well-being.	
FOUNDATIONAL CAPABILITY MEASURES:		
Communications	**3.1.1 A:**	Maintain procedures to provide ongoing, non-emergency communication outside the health department.
	3.2.2 A:	Implement health communication strategies to encourage actions to promote health.

STANDARD 3.1

Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

Health departments must have processes and procedures to communicate information to the public on an ongoing basis. The health department's brand conveys the presence and value of the health department and is designed to establish a positive reputation in the community, reflective of the health department's mission, vision, and values. Health departments also provide critical information to the public about what public health is, what the health department does, and why it matters. To reach broad audiences, effective public health communication requires a variety of methods and formats, such as, print materials, an easily navigable website, and social media. These mechanisms provide opportunities to communicate with the public about the health department's products and services, regulatory and policy activities, role in the community, and the value the department delivers to the community. Health departments should continually monitor, evaluate, and adapt communication strategies to ensure the information is accessible, relevant, and effective to reach intended audiences.

MEASURE 3.1.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain procedures to provide ongoing, non-emergency communication outside the health department.

Purpose & Significance

The purpose of this measure is to assess the health department's procedures for ongoing, non-emergency communications to the public. Procedures are put into practice to ensure consistency in the management of communications on public health issues. Such processes also ensure that the information is in an appropriate format to reach priority sectors or audiences. In order to reach a broad audience, health departments should collaborate with other organizations and work with the news media. Media coverage is a mechanism for disseminating public health information to the community. Knowledge of how media outlets operate (e.g., how to move up in the chain of command or organizational structure) can be a powerful mechanism to ensure messages are heard.

MEASURE 3.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 department-wide procedure or set of procedures	Dated Within 5 years
1. Procedure for ongoing, non-emergency communications. The procedure must:	This requirement relates to ongoing, non-emergency communications (emergency communications are covered within Measure 2.2.5 A). The health department may provide a communication procedure or set of procedures, which includes both non-emergency and emergency communications, as long as the procedure delineates which processes are used for routine communications, emergency situations, or both. There is no required format for the procedure. If a health department works with an office of public affairs, then documentation can come from that office to meet these requirements. Health departments may use procedures that are not specific to the health department, but are government-wide (i.e., Tribe, state, city, or county) or relate to a larger super health agency or umbrella agency. These procedures could demonstrate conformity with the requirement if they apply to the health department's operations. The health department will indicate in the Documentation Form that they use the procedures.		
a. Include the process for ensuring information is accurate and timely.	**For required element a:** To ensure information is accurate, the procedure could describe how the health department, for example, engages experts to review communications, conducts fact checking, checks that the communications are not omitting data that provide important context, or supports transparency by indicating how data may be updated or change over time. To ensure information is timely, the procedure could include, for example, guidance about target timeframes for responding to information requests or flow charts for content review with target timeframes. Ensuring accurate and timely information may also entail strategies to identify and promptly respond to misinformation about public health topics.		
b. Describe the approach to tailoring communication to different audiences.	**For required element b:** Audiences within the community include subpopulations who are at risk, including, for example, those working or living in congregate housing (e.g., homeless shelters, jails or prisons, detention centers, farmworker housing, senior care facilities, group homes, or substance use treatment centers). Tailoring communications so they are appropriate for different audiences could include considerations of, for example, language (e.g., using automated translation features or applications), health literacy, or cultural humility.		

MEASURE 3.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 department-wide procedure or set of procedures	Dated Within 5 years
	Cultural humility considers the way people view, experience, and make choices about their health based on multiple factors (e.g., religion, economic and educational factors, cultural values, beliefs, customs, and ways of living. Cultural humility involves a continual process of openness, awareness of biases, and life-long learning shaped by interactions with diverse individuals and populations. Health departments may consider how cultural, social, and environmental factors affecting priority population(s) may influence their perceptions of communication efforts. For example, deeply rooted beliefs, including personal experiences, historical trauma, societal pressures, or disenfranchisement may prohibit individuals from seeking health care or adopting changes in behavior. This process may also include consideration of unconscious and implicit bias (i.e., the underlying attitudes that people unconsciously attribute to another person or group of people that affect how they understand and engage with a person or group) in terms of information presented or omitted. Health departments may consider using asset-based language (i.e., language focused on the community's strengths, resources, and capabilities, rather than their problems and challenges) in their communications to help make messages more meaningful to a broad audience.		
c. Include the process for coordinating with community partners to promote the dissemination of unified public health messages.	**For required element c:** Partners might include community or volunteer organizations, governing entity, businesses and industries, academic institutions, or others including those who represent priority populations. The procedure could involve, for example, convening meetings with community partners to discuss methods of disseminating unified and accurate information appropriate for the audience. For example, the procedure could include working with partners to develop coordinated press releases, public service announcements (PSAs), or joint web or social media campaigns. An asset-based approach focuses on the context of which community partners are involved and what resources are available in the community to appropriately tailor communication for different audiences.		
d. Describe the process to maintain a contact list of key stakeholders for communications.	**For required element d:** The procedure could involve, for example, the regular review and process steps to update contact information and ensure the list is current. Key stakeholders for communications could include, for example, the public information officers at other health departments (e.g., state, local, Tribal, or military health departments) or other branches of government (e.g., county council, department of education, office of the governor) or communications staff at nonprofit organizations that can help expand the health department's communication reach (e.g., organizations whose constituents represent individuals with particular health concerns or subpopulations in the community). The media is a key stakeholder for communications; however, because the process for maintaining a media list is included in Measure 2.2.5 A, it is not required for this requirement.		

MEASURE 3.1.1 A: Required Documentation 1	Guidance	Number of Examples	Dated Within
		1 department-wide procedure or set of procedures	5 years
e. Identify which department staff position(s) is designated to perform the functions of a public information officer for regular communications. The procedure must define this position's responsibilities, which must include: i. Maintaining media relationships. ii. Creating appropriate, effective public health messages. iii. Managing other communications activities.	**For required element e:** Documentation could be, for example, a job description or other description of responsibilities related to ongoing, non-emergency communications. The public information officer (PIO) function may be a dedicated position or performed by other staff; (e.g., health director, deputy health director, or other assigned staff). The description will reflect the duties of the public information function regardless of the individual's job title. The PIO may be the same position during regular and emergency communications or may be different staff depending on the situation.		

MEASURE 3.1.1 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		1 example that addresses a, b, and c or separate examples demonstrating each required element	2 years or current agreement
2. Capacity to communicate with individuals who are: a. Non-English speaking, b. Deaf or hard of hearing, and c. Blind or have low vision If the service is outside of the health department, the health department must show a current (non-expired) written agreement (contract or MOA/MOU) that demonstrates access to such service.	The intent of this requirement is to demonstrate that the health department is able to access the resources necessary to communicate with individuals who may experience barriers to receiving information, when needed. Documentation could be, for example, a list of staff or contractors who provide interpretation, translation, or specific communication services; technology devices such as a Relay Service; or capacity for communicating with individuals who are deaf or blind, such as, visual aids, close captioning, or use of sign language interpreters for press conferences or presentations. Examples of a specific communication (i.e., translation of one brochure) would not meet the intent of this requirement. Rather, the documentation example would describe access to the translator. The services do not have to be provided directly by the health department but must be available when needed. Tribal health departments may have policies that demonstrate the promotion of culturally appropriate interactions between staff and community members. CHRs or "Cultural Interpreters" may also be available to provide both translation and feedback from community members on program materials or services provided.		

MEASURE 3.1.1 A: **Required Documentation 3**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 2 years
3. Evidence of working with the media to provide non-emergency communication.	The intent of this requirement is to foster a positive relationship with the media. This may contribute to the media's understanding of public health and help ensure they cover important public health issues, which might include championing public health priorities for action. The media include print media, radio, television, web reporters, and diverse media outlets (e.g., urban radio stations; free community newspapers; migrant worker newspapers; or immigrant, ethnically targeted, and non-English language newspapers or radio stations). **Documentation Examples** Documentation could include, for example, a press release sent to media contacts, a press conference, a published editorial concerning a public health issue (written by a department staff person or member of the governing entity), an appearance on a television show (of a department staff person or member of the governing entity), a radio interview (of a department staff person or member of the governing entity), or electronic communications with media contacts.		

MEASURE 3.1.2 A:

Establish and implement a department-wide brand strategy.

Purpose & Significance

The purpose of this measure is to assess the health department's strategy to communicate the value of public health with the aim of establishing a positive reputation in the community. Branding uses a common visual identity to effectively convey the health department's presence and functions and foster a positive reputation among community members. The brand reflects the health department's mission, vision, and values.

MEASURE 3.1.2 A: Required Documentation 1	Guidance	Number of Examples 1 policy, procedure, or set of policies or procedures	Dated Within 5 years
1. A department-wide brand strategy that includes policies or procedures for each of the following:	The intent of this requirement is to outline the standardized approach used by the health department to convey its presence in the community. The health department's brand conveys both its identity and personality, inclusive of its culture, norms, and values. In addition to making community members aware of the existence of the health department through a common visual identify, the brand strategy is designed to foster a positive reputation and trust among community members. Examples of how the branding strategy has been implemented would not meet the intent of this requirement, as implementation examples are covered under Required Documentation 2 and 3. If programs within the department have developed program specific logos, these may be included, as part of the overall branding strategy. PHAB understands that Tribes often use the same logo or Tribal seal throughout the entire Tribe. The same maybe be true of a state, county, or city that uses the same logo for all government agencies in the jurisdiction. In those cases, PHAB will accept that as the organizational branding.		
a. Convey the health department's brand, which demonstrates the presence of the health department, its functions, and services to the entire community.	**For required element a:** Branding communicates what the health department stands for and what it provides that is different from other agencies and organizations. Branding can help to position the health department as a valued, effective, trusted leader in the community. Aligning the branding strategy with the health department's strategic plan can help highlight the role the health department plays in the community. The brand could address, for example, how public health functions promote, protect, and improve the health of the entire community through a population-based lens or upstream approach.		
b. Ensure that health department staff have a clear understanding and commitment to the health department's brand.	**For required element b:** In order to encourage all staff to have a commitment and understanding of the brand, the policy or procedure could include, for example, providing staff training (perhaps, as part of the orientation process or refresher) on developing an elevator speech on what public health is, its purpose, and role in the community; steps for sharing the written branding policy or procedure; staff training on the strategy; or checklists and templates for using the brand. The focus on promoting the population's health can also be infused by intentional policies or procedures to promote employees' health. Modeling that aspect of the health department's brand within the organization, could foster staff commitment.		
c. Integrate brand messaging into department communication strategies.	**For required element c:** The policy or procedure could, for example, discuss how the brand messaging should be integrated into communications such as website, media releases, public service announcements, social media activities, speeches, grant applications, and promotional materials. Brand messaging could include, for example, the health department's mission, vision, values, or positioning statement. Communications strategies consider the community in determining the best way to define and deliver its messages (e.g., to determine which "voice" may be most effective).		
d. Use a common visual identity (logo) to communicate the health department's brand.	**For required element d:** The policy or procedure could include, for example, guidelines on how and where to use the department logo.		

MEASURE 3.1.2 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Implementation of the department-wide brand strategy externally. Each example must address both of the following elements described in Required Documentation 1:	Examples will demonstrate how the brand strategy from Required Documentation 1 communicates the value of heath department products, services, and practices, externally. Examples of a logo on its own would not meet the requirement as the examples will also include brand messaging. Documentation will reflect actual use of brand messaging and the logo, for example, on a website, brochure, or other materials; a template (e.g., blank letterhead) would not meet the intent of the requirement.		
a. Integrate brand messaging into department external communication strategies.	**For required element a:** The brand messaging will highlight, for example, the health department's mission, vision, values, or how the health department provides value in the community.		
b. Use a common visual identity (logo) to communicate the health department's brand	**For required element b:** The logo will be included in both of the examples that are provided. **Documentation Examples** Documentation could include, for example, branding integrated into screenshots of the health department's website, public service announcements, brochures, media releases, or social media.		

MEASURE 3.1.2 A: Required Documentation 3	Guidance	Number of Examples 1 example of signage inside and 1 example of signage outside	Dated Within 5 years
3. Signage displaying the brand or logo. One example must be signage inside and one example must be signage outside the health department's main facility.	**Documentation Examples** Documentation could be photos of the inside and outside of the health department showing use of the logo or brand strategy (defined by the health department within Required Documentation 1). If the health department operates from multiple or satellite locations, the photos could include additional offices, but will show the main office.		

MEASURE 3.1.3 A:

Communicate what public health is, what the health department does, and why it matters.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to inform the public and the governing entity about the role and value of public health and the range of services and programs that the health department provides. To build effective public health programs and ensure sustained funding levels, it is important to foster greater understanding of what public health is and to convey the health department's value, mission, roles, programs, and interventions.

MEASURE 3.1.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example of communication to the public and 1 example of communication to the governing entity or advisory group	**Dated Within** 5 years
1. Communications about:	The intent is that the health department provide information to the public, stakeholders, and governing entity about the importance of the health department and public health to foster understanding about public health and its contributions. Messaging about how the public is part of public health can help populations better understand the personal collective responsibilities of a healthy community and may be used within the example to demonstrate what public health is or why it matters.		
a. What public health is.	**For required element a:** Messaging may describe the scope of public health and the emphasis on the health of populations, for example. To promote understanding of public health, communications may include, for example, what health is and what creates health, including social determinants and root causes of inequities.		
b. What the health department does.	**For required element b:** The examples will speak broadly about activities conducted by the health department. Information about a single health department program or service would not meet the intent.		
c. Why it matters. One example must show communication to the public and the other must show communication to the governing entity or advisory group.	**For required element c:** Messaging may relate to either why public health matters or why what the health department does matters. **<u>Documentation Examples</u>** Documentation could include, for example, a copy of a presentation, advertisements or newspaper inserts, web posting, social media posts, op-eds, or health department brochure. Tribal health department examples of distribution to a governing entity could include Tribal advisory committees and others that advocate for Tribes or comments to federal, state or other advisories committees. Submissions from the Tribe's Legislative Advisor are acceptable forms of documentation. Documentation could be presentations, letters, or fact sheets to Tribal leaders.		

MEASURE 3.1.4 A:

Use a variety of methods to make information available to the public and assess communication strategies.

Purpose & Significance

The purpose of this measure is to assess the health department's use and assessment of a variety of methods and formats to keep the public informed about public health and environmental public health issues, health status, public health laws, health programs, and other public health information. Health departments need to present public health information to different audiences through a variety of methods, including the website and use of social media. Health departments should assess their communications efforts to understand how well they are reaching community members.

MEASURE 3.1.4 A: Required Documentation 1	Guidance	Number of Examples 1 website	Dated Within 1 year
The health department's website or web page URL. The Documentation Form will be used to identify where on the website (URL with navigation, as needed) the following required elements are located:	The intent of this requirement is to disseminate information on the health department and public health issues to the broadest audience possible. The health department may have its own website or have designated pages on another governmental website or internet domain. Required elements will be verified by the Site Visit Team, who will review the health department website; screenshots are **not** required. The health department will indicate on the Documentation Form how to navigate to each of the required elements (e.g., URL with any additional navigation, as needed).		
a. 24/7 contact number for reporting health emergencies.	**For required element a:** The intent of this required element is that a number be specifically provided that indicates how to contact the health department during emergencies, 24/7. This could be through an answering service or another entity for after hours, such as 911 or police dispatch.		
b. Contact number or link to report notifiable or reportable conditions.	**For required element b:** The contact number or link to report notifiable or reportable conditions could be the same number as the 24/7 contact number for reporting emergencies or could be a different number or link.		
c. The jurisdiction's community health assessment and community health improvement plan. (If not applicable for a Tribal health department, this may be indicated in the Documentation Form.)	**For required element c:** The links to the state/Tribal/community health assessment and state/Tribal/community health improvement plan could be provided or the assessment and plan may be embedded within a public website (e.g., dynamic CHA). The assessment or plan could be housed on a partner's website; however, the health department website will include a link to that website. Tribal health departments can decide through what means they make public health data available to their population or community. Data do **not** need to be posted on the Tribal health department website. If the Tribal health department does not post public health data, that should be indicated on the Documentation Form.		
d. Public health data specific to the health department's jurisdiction. (If not applicable for a Tribal health department, this may be indicated in the Documentation Form.)	**For required element d:** The web page could include, for example, links to factsheets, data reports, morbidity and mortality data, social determinants data, or dynamic incidence and prevalence data. Data could be collected by others, for example, school district, police, or local institute of higher education. Tribal health departments can decide through what means they make public health data available to their population or community. Data do not need to be posted on the Tribal health department website. If the Tribal health department does not post public health data, that should be indicated on the Documentation Form.		

MEASURE 3.1.4 A: Required Documentation 1	Guidance	Number of Examples 1 website	Dated Within 1 year
e. Links to public health-related laws or codes including enforcement related laws.	**For required element e:** While the health department's website will include a link to access public health related laws or codes, the laws or codes themselves may be on a different website.		
f. Links to permits and license applications, as applicable. (If not applicable, this may be indicated in the Documentation Form.)	**For required element f:** Permits and license applications the health department makes publicly available should be easy for the public to access. If the health department does not administer any permits or licenses, the health department will indicate that on the Documentation Form.		
g. Information about or materials from public health program activities conducted by the department.	**For required element g:** Information or materials from program activities could include, for example, infectious disease, chronic disease, environmental public health, prevention, and health promotion.		
h. Links to CDC and other public health-related federal, state, or local agencies, as appropriate.	**For required element h:** Links could include, for example, links to the state health department or other health departments in the region. Links could also provide users with additional ways to gather information on a specific topic area.		
i. The name of the health department director.	**For required element i:** The health department director listed on the website could be either the health department's top executive or the medical director/health officer. The names of the health department's leadership team or additional staff may also be included.		
j. The address of the health department.	**For required element j:** If the health department has multiple facilities, the address of at least one will be included on the website. The health department can determine which address(es) is most appropriate.		
k. A method for the public to submit comments to the health department.	**For required element k:** The method(s) provided on the website for the public to provide comments or feedback could be an email address, a text box, a feedback survey, or other method.		
l. Evidence of at least one update to the website within the past year.	**For required element l:** Website updates could be demonstrated through, for example, "last updated" dates posted on the webpage, emails with IT staff, or other documentation demonstrating an update has occurred within the timeframe requirement.		

MEASURE 3.1.4 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 2 years
2. Social media used to provide information to the general public about public health issues or health department functions.	Social media provides additional mechanisms to share information about the health department, its programs and activities, and health promotion messages with the public, while facilitating communication (social networking). Common social media platforms include, but are not limited to: Facebook, Twitter, LinkedIn, Instagram, or Pinterest. Both examples provided may be from the same social media account.		

MEASURE 3.1.4 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 5 years
3. Assessment of one communication strategy.	The intent is that the health department assess its communications strategies to ensure messaging is responsive to community needs. The assessment does **not** need to be complex or costly (i.e., the health department does **not** need to contract with an external marketing or communications vendor). The assessment could consider a single mode or method, or topic area, or campaign (e.g., tracking web or social media hits), or multiple modes, methods, or topics. For example, the health department could assess its website analytics (reach or hits) or social media content (visits, new or total followers, impressions, or shares). Other examples could be to assess the health department's media mentions or uptake of press releases/PSAs among media outlets or content used by partner organizations. Other examples could include gathering input from the community about the health department's current website, social media, or other communication to understand what topics or methods meet their needs (e.g., through a survey, interviews, or focus group). **Documentation Examples** Documentation could include, for example, meeting minutes showing discussion of evaluation findings among staff, a presentation, or report.		

STANDARD 3.2

Use health communication strategies to support prevention, health, and well–being.

Health communication integrates health education and promotion to provide information to encourage healthy actions and influence behavior change. Health promotion policies, programs, processes, and interventions are the mainstay of public health improvement efforts. While there are many policy and environmental factors that influence health, health education is an important component of encouraging the adoption of healthy behaviors. Health education provides information to empower individuals and communities to make decisions to improve and protect their health. Health education involves gathering knowledge about the health issue and the target population and sharing that information in a manner and format that can be used effectively by the population.

MEASURE 3.2.1 A:

Design communication strategies to encourage actions to promote health.

Purpose & Significance

The purpose of this measure is to assess the health department's approach to designing communication strategies to foster actions to promote health and address preventable health conditions. Health communication draws upon expertise in the areas of health education, health promotion, and communication science to empower individuals and communities to make healthy choices based on providing accurate and timely information that is tailored toward meeting their needs. To effectively influence and encourage the adoption of healthy behaviors, health communication efforts should be conducted in tandem with policy, environmental, and systems change (concepts covered within Domain 5).

MEASURE 3.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 department-wide approach	Dated Within 5 years
1. A department-wide approach for developing and implementing communication strategies designed to encourage actions to promote health. The planned approach must include processes for:	The intent of this requirement is to show the department-wide approach or framework for communications designed to inspire behavior change in order to develop consistent health messaging. A specific example of a communications strategy or a framework that applies to a single program or area would not meet the intent of this requirement. This does **not** need to be prescriptive or formalized into a separate plan or policy or procedure but could be demonstrated through a checklist or training materials that support health communication planning and strategies. Unlike the health department's overall communications procedures (which will be inclusive of all efforts to provide information to the public), this approach will focus specifically on efforts that are designed to encourage members of the public to consider taking particular actions. Health communication strategies should be based on available evidence-based, practice-based, or promising practices. At the same time, to be effective, health communication strategies may take into account input from the priority population to ensure messages are easily understood and most likely to have an impact. There may be times when these two goals—following an evidence-based practice and tailoring the strategy to the priority population(s)—are in tension. Because an evidence-based education program has already been tested and validated, it may be appropriate to implement it as it was designed. For example, health departments might select an evidence-based tobacco campaign that was designed for youth through the use of social media or PSAs using youth voices. On the other hand, evidence-based sexual health or vaccination messaging or modes may require tailoring to address social, cultural, or faith norms. A communications approach can explain how the health department will identify if there are evidence-based or promising practices and determine if and how it is appropriate to tailor the strategies to meet the unique needs and characteristics of the community, which may vary depending on the size of the population, geography, social or cultural relevance, and other factors.		
a. Determining that an issue is a priority for communication efforts.	**For required element a:** Determination of priorities could include, for example, selection based on the identification of priority populations that are at higher risk for poorer health outcomes. Sources of information could include, for example, state/Tribal/community health assessment or improvement plan, surveillance or other data sources, or community input. The approach (e.g., checklist or training) may indicate what sources the health department consults in determining priorities or may describe what the prioritization process entails.		
b. Identifying appropriate evidence-based or promising practices.	**For required element b:** The approach could describe what resources the health department consults to identify if there are evidence-based or promising practices that meet the needs for a particular communications effort or how the health department considers how evidence-based practices should be tailored to the population or target audience. Due to the limited availability of evidence-based practices or promising practices in Tribal communities, Tribes may identify methods to adapt models or create models based on a cultural framework.		

MEASURE 3.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 department-wide approach	Dated Within 5 years
c. Engaging the priority population(s) in the design, development, or implementation of strategies.	**For required element c:** The approach could describe processes by which input from the priority population(s) is used to help shape the content, dissemination, or implementation. Community input may be used to help a health department determine which existing communication materials are appropriate for the community or to tailor the dissemination based on community factors. In addition, if a health department is using an evidence-based practice, the health department can describe how it consults the priority population during the selection of the evidence-based practice. Processes might also consider methods to engage priority populations equitably (e.g., compensating for time, or in-kind support). Tribal health departments could include descriptions of talking circles, Tribal oversight committees, Tribal leader meeting, community meetings, or Tribal consultation meetings.		
d. Ensuring consistency with procedures for communications (Measure 3.1.1) about: i. Ensuring information is accurate and timely. ii. Tailoring communication for different audiences. iii. Informing or coordinating with community partners to promote the dissemination of unified public health messages.	**For required element d:** Methods for ensuring consistency with communications procedures could include, for example, making sure checklists or trainings are available to staff developing health communication strategies or implementing a review process that checks materials for their accuracy, timeliness, appropriateness for different audiences, and coordination with community partners. **Documentation Examples** A planned approach could be documented through, for example, a checklist, training module that includes these required elements, policies and procedures, or other documentation that describes the factors to consider in developing and implementing health communication strategies.		

MEASURE 3.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Implement health communication strategies to encourage actions to promote health.

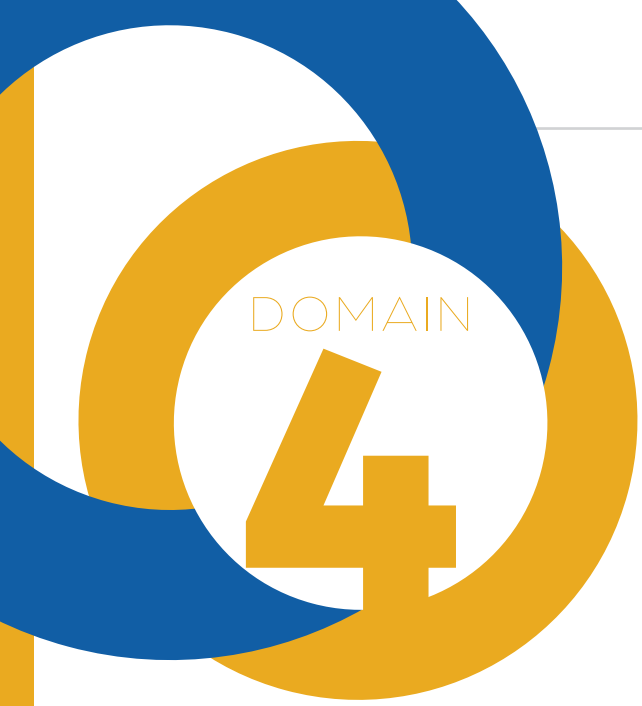
Purpose & Significance

The purpose of this measure is to assess implementation of the health department's communication strategies to the populations that it serves in order to encourage changes related to health risks, health behaviors, disease prevention, and well-being approaches. Culturally sensitive and linguistically appropriate information ensures that public health information is understandable. To reach intended audiences, communications must be accurate, timely, and provided in a manner that can be understood and used effectively by the priority population. For the information to be trusted, health messaging should be coordinated with others who are providing public health information to the public.

MEASURE 3.2.2 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Health communication strategy implemented to encourage actions to promote health, which includes:	The intent of this requirement is to demonstrate how the health department implemented the approach described in Measure 3.2.1 A to put in place specific communication strategies. Health communication strategies could address a broad range of topics, including, for example: ▪ Health risks, for example, high blood pressure or high cholesterol. ▪ Health behaviors, for example, tobacco use, exercise habits, or unprotected sexual activity. ▪ Disease, illness, or injury prevention, for example, seat belt use or immunizations. Chronic disease program areas could include, for example, diabetes, obesity, heart disease, HIV, substance abuse, or cancer.		
a. The final content that references an action that members of the public should take and describes why the action should be taken.	**For required element a:** The final content of the health message will convey action members of the public should take with a description of the reason(s). For example, a youth tobacco health message might recommend teenagers avoid vaping or other tobacco products and explain why all tobacco is harmful, or a social media post might link to a resource for parents about how to talk with their teenage children and describe why maintaining a dialogue matters.		
b. A description of how the health department strived for cultural humility and considered linguistic appropriateness. (The description may be indicated in the Documentation Form.)	**For required element b:** The health message could, for example, be offered in multiple languages, include simplified wording and plain language, include visual aids for those of low literacy, include appropriate to real life situations of the priority audience, or consider health literacy. Cultural humility considers the approach for tailoring communication messages in the context of underlying values, perceptions, and beliefs. National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare is a resource for these efforts. Required element b may be described within the Documentation Form.		
c. How the information was shared or distributed. (How the information was shared may be indicated in the Documentation Form.)	**For required element c:** Distribution to the public could include, for example, public service announcements, radio or television interviews, or digital media (e.g., websites or social media). Distribution might also include public forums, health fairs or events, or presentations. Required element c may be described within the Documentation Form.		

MEASURE 3.2.2 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
At least one example must be of an evidence-based or promising practice. (The citation or source may be indicated in the Documentation Form.) At least one example must demonstrate how the content or dissemination was shaped by input from the priority audience. The two examples must be from different public health topics, one of which must address a chronic disease program.	A health department could document that it is using an evidence-based or promising practice by including a citation of the study or source of the program in its Documentation Form. The evidence-based or promising practice may relate to the topic of the message, or concepts in the way it was designed considering communication science, health promotion, or health education evidence-based or promising practices. Documentation of input from the priority population could be, for example, a report of findings from a focus group, key informant interviews, or pull-aside testing; or minutes from a town meeting with the priority population or a meeting of an advisory group that includes members of the priority population. To demonstrate how that input was used in developing the communications strategy, the documentation could include a final document with highlights showing how the information from the priority audience was used. If appropriate, the documentation could be supplemented by a description in the Documentation Form—for example about how the dissemination strategy was developed based on the feedback. Input from the priority audience gathered during the development of messages is intended to help shape the final content or dissemination strategy. Feedback after messages are delivered (such as a program evaluation) would not be appropriate unless the documentation shows how the health department modified the content or dissemination strategy and delivered the revised version. The same example could show both how an evidence-based or promising practice was used and how it was adapted based on community input. **Documentation Examples** Documentation showing distribution, could be, for example, a public presentation, distribution of a press release, the media distributing a communication, brochure or flyer distributed to the public, or public service announcement.		

MEASURE 3.2.2 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. Unified messaging coordinated with other health departments (Tribal, state, or local), community partners, or the governing entity.	Coordinated messaging with others who are providing public health information to the public improves trust and reduces confusion. This could be the same example provided in Required Documentation 1 or it could be a different example. **Documentation Examples** Documentation could include, for example, a fact sheet produced in coordination with other health departments or partners, a public service announcement developed in coordination with the governing entity, an email chain or memorandum with other health departments or partners, meeting minutes where messaging was discussed, or documented phone conversation discussing the message.		



Strengthen, support, and mobilize communities and partnerships to improve health.

Domain 4 focuses on health departments' convening and mobilizing of community partnerships and coalitions that will facilitate public health goals being accomplished, promote community resilience, and advance the improvement of the public's health. Public health can broaden its impact by doing things with the community rather than doing things to the community by using a community engagement approach. Members of the community possess unique perspectives on how issues are manifested in the community, what and how community assets can be mobilized, and what interventions will be effective. Community members are important partners in identifying and defining public health issues, developing solutions or improvements, advocating for policy changes, communicating important information, and implementing public health initiatives. Aligning and coordinating the public health system's efforts towards health promotion, disease prevention, and equity across a wide range of partners is essential to the success of health improvement.

DOMAIN 4 INCLUDES **ONE** STANDARD		
Standard 4.1:	Engage with the public health system and the community in promoting health through collaborative processes.	
FOUNDATIONAL CAPABILITY MEASURE:		
Community Partnership Development	**4.1.2 A:**	Participate actively in community health coalition(s).

STANDARD 4.1

Engage with the public health system and the community in promoting health through collaborative processes.

Health improvement efforts will be most effective when the health department works with the communities that it serves. Community understanding and support is critical to the implementation of public health policies and strategies. It is important to gain community input to ensure that a policy or strategy is appropriate, feasible, and effective. Ongoing dialogue about community issues, discussions about options and alternatives, and community ownership increase the effectiveness of health improvement efforts. Collaboration with other members of the public health system and with members of the community develops shared responsibility and provides various perspectives and additional expertise. Collaboration allows the community's assets to be mobilized, coordinated, and used in creative ways for increased community efficacy in building health and well-being and advancing health equity.

MEASURE 4.1.1 A:

Engage in active and ongoing strategic partnerships.

Purpose & Significance

The purpose of this measure is to assess the health department's engagement with partners in the public health system or other sectors and how these partnerships enable them collectively to address specific public health issues or their causes and to promote health in particular populations. Building relationships with other organizations takes time and an ongoing commitment to understand the language and culture of the other organization and to determine strategies that benefit both organizations. Well-established partnerships can be leveraged as new needs arise or in the face of emergencies.

MEASURE 4.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example each from two different partner organizations	**Dated Within** 2 years
1. A collaborative activity to address a specific public health issue or population that builds on an ongoing partnership with another organization. In addition to the example of the collaborative activity, the Documentation Form or other documentation must also include the following to demonstrate each example arose from an ongoing collaboration:	The intent of this requirement is to document examples of the health department engaging in ongoing strategic relationships with other organizations that laid the groundwork for an additional collaborative activity. Coalitions the health department participates in would **not** meet the intent and are covered in the following measure. The health department will describe relationships with two partner organizations. For each collaboration the health department will provide documentation of one collaborative activity (e.g., a joint event, a grant application, a collaborative outreach or enrollment effort, or coordination on public messaging) and describe required elements a-d. Required elements a-d may be described within the Documentation Form.		
a. Name and brief description of the partner organization.	**For required element a:** The partner could be another health department (e.g., a neighboring local, state, Tribal, or military health department), another governmental entity (e.g., transportation, energy, education, emergency management, aging, law enforcement, housing, community development, economic development, parks and recreation, planning and zoning), hospital or other health care provider, community foundation or philanthropist, voluntary organization, faith-based organization, community organizer or advocacy organization, business, chamber of commerce, academic institution, local death review organization, public health institute, environmental public health group, or group that represents minority health.		
b. Description of how long the partnership has been in place.	**For required element b:** The partnership may have been established more than 2 years before documentation submission. It is the example of the collaborative activity that will be dated within 2 years of documentation submission.		

MEASURE 4.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example each from two different partner organizations	**Dated Within** 2 years
c. Description of intentional actions taken to maintain the ongoing relationship.	**For required element c:** The intent of this required element is to show that the health department has taken deliberate steps to maintain an ongoing relationship—that is, ongoing interaction to build trust and familiarity over time to facilitate new collaborative activities. This could include, for example, establishing monthly or quarterly meetings; establishing data sharing agreements; co-locating services with another organization; having staff of the health department serve on an advisory group for the other organization and vice versa; having health department staff go through orientation or training at the other organization and vice versa; or explicitly assigning a staff member as a liaison to another organization and vice versa. These steps could have happened more than 2 years before documentation submission.		
d. A brief description of how the example provided demonstrates that this is a collaborative activity that builds on the ongoing partnership. The health department must document 1 collaborative activity from each of **two** relationships with different organizations.	**For required element d:** The intent of this required element is to demonstrate how an ongoing relationship led to the example of the collaborative activity. For example, if a health department had an ongoing relationship with a school district to enroll families in food assistance programs, that may lead to an opportunity for the health department to participate in a review of nutritional offerings in the cafeteria. Similarly, a health department with an ongoing relationship with an FQHC to enroll clinic patients in WIC, might have been able to build on that relationship to collaborate on a vaccine clinic.		

MEASURE 4.1.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Participate actively in community health coalition(s).

Purpose & Significance

The purpose of this measure is to assess the health department's engagement in coalition(s) comprised of partners representing various sectors and community members working together to address issues that impact health and health equity. Coalitions provide the opportunity to leverage resources, incorporate various perspectives and expertise, coordinate activities, and employ community assets in new and effective ways. Coalitions include engagement with community members so that they are involved in the process and participate in the decisions made and actions taken.

MEASURE 4.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples of topic or population specific coalitions or one example of a coalition that works on 2 or more issues	**Dated Within** 2 years
1. Active participation in a current, ongoing community coalition that addresses multiple population health topics or in two coalitions that each address a single health topic or population. Documentation must include:	The health department may document a coalition that addresses 2 or more community health issues or document 2 topic or population specific coalitions. While the coalition may have been established more than 2 years before documentation submission, the coalition will be ongoing at the time of documentation submission. That is, a coalition that has disbanded or is no longer active would **not** meet the intent of this requirement. Coalitions provide a mechanism to address complex issues through multi-sector collaboration to achieve a common goal. Over time, coalitions may mature to include bi-directional decision making or community-led engagement. The coalition may address a wide range of community health issues and may be the same group that developed the state/Tribal/community health assessment or community health improvement plan. Topic or population specific coalitions could address, for example: tobacco prevention, maternal and child health, HIV/AIDS, childhood injury prevention, immigrant health issues, newborn screening, integrated chronic disease prevention, or childhood obesity. Coalitions could address issues that impact on the public's health, for example, social or racial injustice, climate change, child labor, housing, jobs and job training, transportation, parks and recreation, or smart growth and the built environment. Specific populations may be the focus of the partnership or coalition, such as, teenagers, older adults, residents of a zip code or zip code cluster with poor health outcomes, or people who work in a particular industry.		
a. Purpose or intended goals of the coalition, including how they address disparities or inequities.	**For required element a:** The stated purpose or intended goals should outline what health issues or topics are addressed by the coalition, including a focus on addressing health inequities or disparities, for example, specific zip codes, neighborhoods, age groups, or ethnicities that have an inequitable share of poorer health outcomes. Factors that contribute to health inequities might also consider, for example, policies (e.g., taxation, education, transportation, or insurance status) or aspects of the built environment, such as, walkability, availability of grocery stores in specific neighborhoods, or differences in transportation routes to health care services in the jurisdiction. The purpose or intended goal may emerge from, for example, state/Tribal/community health improvement planning efforts, strategic planning, data analysis, or community input.		
b. Representatives from multiple sectors.	**For required element b:** Partners could include, for example, elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, businesses, industries, major employers in the community, chambers of commerce, civic groups, faith-based organizations, non-profit organizations, academia, or other health departments (state, Tribal, local, or military).		

MEASURE 4.1.2 A: Required Documentation 1	Guidance	Number of Examples	Dated Within
		2 examples of topic or population specific coalitions or one example of a coalition that works on 2 or more issues	2 years
c. Participation of community members.	**For required element c:** Community members could include, for example, individual residents that have expressed an interest, community members with lived experience with health issues or disparities, or individuals that are seen in their communities as leaders. Community members are intended to be members of the public. Government employees and public health or health care professionals would not meet the intent of including community members.		
d. Modes and frequency of interaction. (If the modes and frequency of interaction is not evident in the example, it could be indicated in the Documentation Form.) The health department must actively participate in the coalition, although the coalition may be convened or facilitated by a representative of another community organization or agency.	**For required element d:** The modes (methods of communication) and frequency of interaction will be described. For example, monthly or quarterly meetings could take place virtually or in-person or other regular communications, such as each member reporting quarterly into a shared file system could be described. Each coalition will determine the modes and frequency of interaction necessary for the group. The modes and frequency of interaction may be indicated in the Documentation Form. **Documentation Examples** Documentation could be a summary or report of the coalition(s), indicating ongoing activities; meeting minutes and agendas; progress reports; or evaluations. A roster of members will not be sufficient for this requirement, but it could be used to demonstrate required elements b and c.		

MEASURE 4.1.2 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		2 examples	5 years
2. Strategies implemented through the work of the coalition(s) from Required Documentation 1. Both examples could be provided from the same coalition if multiple coalitions are provided above.	The intent of this requirement is to document strategies that have been implemented. Future plans or a workplan alone would **not** meet the intent of this requirement. However, if the coalition succeeds in a strategy of having an initiative placed on a ballot or a piece of legislation introduced, it would demonstrate the intent of the requirement even if the ballot initiative or legislation was not passed. The strategies implemented could be a change in the community, a change in policy, or a new or revised program that was implemented through the work of the coalition. Strategies could be, for example, an increase in the number and types of locations where tobacco use is not permitted, an increase in the number of miles of bike paths, a local zoning change, the removal of soda vending machines from public schools, an increase in the frequency of restaurant inspections, an increase in the number of community police stations, or policies that address social determinants of health.		

MEASURE 4.1.3 A:

Engage with community members to address public health issues and promote health.

Purpose & Significance

The purpose of this measure is to assess the health department's authentic engagement with community members to partner with them in addressing public health issues and concerns. Community engagement is an ongoing process of dialogue and discussion, collective decisions, and shared ownership. Public health improvement requires social change; social change takes place when the population affected by the problem is involved in the solution. Community engagement also has benefits of strengthening social engagement, building social capital, establishing trust, ensuring accountability, and building community resilience.

MEASURE 4.1.3 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 example	5 years
1. Strategy implemented to promote active participation or eliminate barriers to participation among community members.	The intent of this requirement is to demonstrate specific strategies or actions the health department has taken to encourage participation of community members in addressing public health issues, particularly efforts to empower populations whose voices might not otherwise be heard to co-lead efforts to improve community health. The intent of this requirement is to engage individual community members, **not** organizations representing population groups. Strategies may be led by the health department, or the health department might participate in these strategies in partnership with others. Examples of strategies could include: ▪ Implementing a leadership/civic engagement academy that gives community members the opportunity to build their capacity. ▪ Offering mini-grants to support community-led initiatives. ▪ Engaging in participatory budgeting (e.g., letting community members participate in decision making about how to allocate a set amount of financial resources). ▪ Providing transportation mechanisms or childcare to facilitate participation by community members. ▪ Providing compensation (monetary or nonmonetary) for time and contributions. ▪ Making the decision-making structure inclusive and transparent to empower community members or developing mechanisms for shared ownership in the process (e.g., shared ownership in setting agendas or priorities). ▪ Enhancing residents' capacity to understand levers of power or influence in policy change. ▪ Supporting grassroots interventions and initiatives with access to funding or eliminating barriers by changing institutional culture to provide access to community leadership or buy-in. ▪ Ensuring consistency and transparency in how the health department engages with the community, such as, creating space for community participation on workgroups, hosting meetings in locations and times convenient to community members or partners, demonstrating follow through on equity or other commitments, or establishing systems or structures to include community-led initiatives. **Documentation Examples** Documentation could include, for example, a summary or report; meeting minutes describing the implementation of the strategy; or news articles. If appropriate, the documentation could be supplemented by a description in the Documentation Form—for example, the documentation may show one instance of how the health department creates space for community participation in workgroups and the Documentation Form could describe that how that strategy was implemented consistently.		

DOMAIN 5

Create, champion, and implement policies, plans, and laws that impact health.

Domain 5 focuses on health departments' ability to influence policies, plans, and laws by working across sectors with partners and the community to consider the health implications, correct historical injustices, and provide fair and just opportunities for all to achieve optimal health. Health departments play an important role to serve as a primary and expert resource for reviewing and evaluating policies for their impact on health by considering the evidence and gathering input from among affected stakeholders.

A collaborative health improvement planning process is an opportunity for the community to determine which strategies can best leverage assets and address health needs. Health departments and their partners can consider a range of policy, systems, and environmental (PSE) changes aimed at creating conditions in which all residents have the opportunity to be healthy. Health improvement planning efforts can take a life course approach to support positive life trajectories.

DOMAIN 5 INCLUDES **TWO** STANDARDS		
Standard 5.1:	Serve as a primary and expert resource for establishing and maintaining health policies and laws.	
Standard 5.2:	Develop and implement community health improvement strategies collaboratively.	
FOUNDATIONAL CAPABILITY MEASURES:		
Policy Development & Support	**5.1.2 A:**	Examine and contribute to improving policies and laws.
Community Partnership Development	**5.2.2 A:**	Adopt a community health improvement plan.
Equity	**5.2.4 A:**	Address factors that contribute to specific populations' higher health risks and poorer health outcomes.

STANDARD 5.1

Serve as a primary and expert resource for establishing and maintaining health policies and laws.

Public health policies and laws should reflect current public health knowledge and emerging issues. Health departments also have access to community and population data and information that can help determine the current or potential impact of policies. Laws may need to be revised to address social and environmental factors that place populations at health risk.

The term "laws" as used in The Standards refers to ALL types of statutes, regulations, rules, executive orders, ordinances, case law, and codes that are applicable to the jurisdiction of the health department.

MEASURE 5.1.1 A:

Maintain awareness of public health issues that are being discussed by those who set policies and practices that impact on public health.

Purpose & Significance

The purpose of this measure is to assess the health department's ability to be aware of and knowledgeable about what policies and laws are being considered and their impact on public health. This could enable the health department to influence the development of those policies. An important role for health departments is influencing the adoption of effective public health policies and laws by being a resource for science-based public health information. A Health in All Policies (HiAP) approach could focus the health department's attention on the range of laws that could impact the health of the population.

MEASURE 5.1.1 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	2 years
1. Evidence that the health department stays informed of the public health issues that are being discussed by the health department's governing entity or advisory board, elected officials, or other individuals or entities that set policies and laws that impact public health or the health department.	The intent of this requirement is to show how the health department is aware and informed of issues under consideration by the governing entity, elected officials, or entities that set policies and laws, which could include, for example, regulations, ordinances, or executive orders. Policies being discussed could be at the Tribal, state, federal, or local level. Local elected officials include county (e.g., county manager, board of commissioners, or supervisors) or city officials (e.g., mayor, city council, board of commissioners, or supervisors). State elected officials include the governor, council of state, or state legislators. Tribal elected or appointed officials vary depending on the Tribal Nation's governance. Some examples include: Principal Chief, Chief, President, Chairperson, Governor, Tribal Council Member, or Health Oversight Committee. Government officials include elected or appointed positions or other staff of government departments (e.g., education, labor, or insurance). Health departments may also indicate how they are tracking federal policies that will have implications in their jurisdiction. A Health in All Policies approach may be used to consider current or proposed policies or laws related to, for example, education, transportation, or other sectors that could have an effect on the public's health or on health equity. The examples may also address policies or laws that have a direct effect on the operations of the health department (e.g., changes that may affect the health department's budget or workforce) or that would affect the ability of the health department or a governing entity or advisory board to issue or enforce a public health order, therefore impacting the ability to effectively promote and protect the public's health. **Documentation Examples** Documentation could include, for example, meeting minutes and agendas showing a discussion of policies or laws and their impact on health; a log of legislation impacting health and environmental public health; health department membership on a listserv that discusses public health policy issues; or newsletters, reports, or summaries showing the health department is aware of policy-related issues discussed by elected officials or governing entities.		

MEASURE 5.1.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Examine and contribute to improving policies and laws.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to review policies or laws and share findings of that review in order to contribute to and influence the development or modification of policies or laws that impact public health. Health departments should act as a champion of policy change in their community. This requires health departments to engage with policy makers to provide sound, science-based, current public health information that should be considered in setting and revising policies and laws. Seeking input from and developing strategic partnerships with health-related organizations, community groups, and other organizations can increase support for policies with public health implications. Health in All Policies (HiAP) considers health as created by a multitude of factors beyond healthcare, requiring a collaborative approach to integrate and articulate health considerations into policy making across sectors.

MEASURE 5.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. A review of a current or proposed policy or law shared with those who set or influence policy. Each review must include:	The intent of this requirement is to demonstrate how the health department serves as a primary and expert resource by reviewing policies or laws for their implications on health, gathering input from stakeholders as part of that review, and sharing the results of the review with those who set or influence policies. The health department could use examples developed through engagement on a committee, coalition, or association focused on policies or legislative issues, as long as such examples show how the health department contributed; it would **not** be sufficient if documentation only demonstrates belonging as a member or receiving legislative or policy news or updates. The examples might consider policy, systems, and environmental (PSE) interventions to address economic, social, structural, or physical changes to the environment or to the underlying causes of health disparities, such as, socioeconomic conditions, social determinants of health, or aspects of environmental justice. Policies that only affect the health department's staff (e.g., HR policies) do **not** meet the intent of this requirement. Documentation can address policies either in effect or proposed and can address policies at the local, Tribal, state, or federal level. The policies or laws may relate to executive orders at the local or state level or consider policy-related advisories or recommendations. Reviews could be of a policy or law that the health department enforces (e.g., laws related to indoor smoking, issuance of quarantine orders, or ability to issue a public health emergency). Reviews could also be of a policy or law that others enforce but impact public health (e.g., helmet use laws, school nutrition requirements, sale of tobacco products to minors, animal rabies vaccination laws, school requirements for proof of childhood vaccinations, regulations to reduce carbon use or pollutants, occupational health and safety regulations, minimum and living wages, housing or eviction protection laws (including ones designed to address redlining), eligibility requirements for SNAP, or policies to address lead abatement). Laws about data sharing or exchange would meet the intent of this requirement as the ability to share information across jurisdictions enables a unified response to public health challenges. The review of the policy or law could include a cost analysis, which may be conducted by the health department or by another entity. Health departments could consider engaging legal counsel in the review of policies of laws. Sharing with those who set policies or stakeholders that influence policy could be demonstrated through, for example, the distribution of materials, presentations, or official testimony. It is **not** necessary for the health department to share the entire review with those who set policy. The health department could, for example, share an executive summary or a brief memo highlighting key findings from the review for policy makers. Those who set or influence policy could include, for example, governing entities, such as the Board of Health or advisory board; local, state, or federal legislative bodies or elected officials; local boards of education or transportation; Tribal District Chairpersons; elected Tribal council committees; Tribal Legislative Counsel; Tribal Elected/Appointed officials; or Tribal Oversight Committees.		

MEASURE 5.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
a. Consideration of evidence-based practices, promising practices, or practice-based evidence.	**For required element a:** Consideration of evidence-based practices, promising practices, or practice-based evidence could include, for example, a comparison to similar laws, the use of model public laws, or an analysis of laws by a practice-based research network. The intent of the requirement is to review current or proposed laws or policies considering the best available evidence. These could be demonstrated through, for example, meeting minutes, reports, presentations, or some other record of the discussion of the review. Because there may be limited availability of evidenced-based practices or promising practices in Tribal communities, Tribes could provide examples of practice-based evidence, including, for example, drawing from the lessons learned from similar policies that have been implemented in Indian Country. Health departments could also adapt models or create models based on a cultural framework or traditional forms of governance.		
b. Assessment of the impacts of the policy or law on equity.	**For required element b:** The assessment of the equity impacts of current or proposed laws or policies might include an assessment of whether laws/policies have a disproportionate effect on one or more subpopulations within the jurisdiction. For example, transportation policies may have a greater effect on individuals who rely on public transit. Participation in a health impact assessment that considered the disproportionate effects on different people could be provided. The assessment could consider how laws or policies correct injustices that have contributed towards higher health risks or poorer health outcomes among subpopulations.		
c. Input gathered from stakeholders or strategic partners. For state health departments at least one stakeholder in required element c must be a local or Tribal health department(s). Documentation must include both the review **and** how it was shared.	**For required element c:** Input could be gathered from community stakeholders or strategic partnerships including collaboration on the review with, for example, governmental agencies (e.g., departments of transportation, aging, substance abuse/mental health, education, planning or community development); healthcare-related organizations (e.g., a hospital system); community groups or organizations (e.g., those representing populations experiencing health disparities or inequities); private businesses (e.g., talking with restaurant owners related to food code); non-profits; or the general public. Input could be sought through, for example, public notice, town forums, meetings, hearings, or request for input on the health department's web page. The health department could also include input received from a governing entity or advisory board if the governing entity or advisory board does not have the authority to set the law or policy under review. For example, the health department could seek input from a local board of health about a state-level policy or it could seek input from an advisory board about a local policy. For state health departments, the intent of gathering input from health department(s) as a stakeholder is to ensure collaboration with Tribal or local health departments in reviewing policies or laws that may impact those Tribal or local health departments and the populations they serve. It is **not** necessary that the health department demonstrate input from the stakeholders about the entire analysis or the entire law or policy. The health department could, for example, gather stakeholder input on just one portion of the analysis or one facet of the law or policy.		

MEASURE 5.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
	Documentation Examples Documentation of the review (required elements a and b) could be, for example, a health impact assessment, position papers, white papers, or legislative briefs that include recommendations for amendments. The examples could also be demonstrated through, for example, meeting minutes or other records of discussion, written testimony, or transcript of oral testimony. The documentation of gathering input from stakeholders (required element c) could be incorporated into the review (for example, if the memo or testimony describes the input from stakeholders) or it could be provided separately through, for example, meeting minutes, reports, presentations, or some other record summarizing the input received from stakeholders. Evidence of sharing the results of the review with those who influence policy could be demonstrated by including email correspondence or other evidence of dissemination or record of public testimony.		

STANDARD 5.2

Develop and implement community health improvement strategies collaboratively.

The community health improvement plan is a long-term, systematic plan to address issues identified in the community health assessment. The purpose of the community health improvement plan is to describe how the health department and the community it serves will work together to improve population health in the jurisdiction. The community, stakeholders, and partners can use a solid community health improvement plan to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.

The plan is more comprehensive than the roles and responsibilities of the health department alone, and the plan's development and implementation must include participation of a broad set of community stakeholders and partners. The planning and implementation process is community-driven. The plan reflects the results of a collaborative planning process that includes significant involvement by a variety of sectors that make up the public health system.

The Standards use the term "community health improvement plan" to refer to planning at the state, Tribal, or local level. For state health departments, this is often referred to as a state health improvement plan and will address the needs of all residents in the state. For local health departments, the community health improvement plan will address the needs of the residents within the jurisdiction it serves. A local health department's plan may address the needs of residents within a larger region, but the submitted plan will include details that address the requirements specific to the jurisdiction applying for accreditation. Tribal health departments will define their community. The community health improvement plan is often referred to as a Tribal health improvement plan and will address the community as defined by the Tribal health department. For example, it may address the needs of all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

MEASURE 5.2.1 A:

Engage partners and members of the community in a community health improvement process.

Purpose & Significance

The purpose of this measure is to assess the health department's collaborative community health improvement planning process and the participation of stakeholders. While the health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other agencies and organizations to plan and share responsibility for health improvement and advancing equity. Other sectors and stakeholders have access to additional data and bring different perspectives that will enhance planning. The health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

MEASURE 5.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
1. A collaborative process for developing the community health improvement plan (CHIP), which includes:	This may be referred to as a state health improvement planning process, Tribal health improvement planning process, or other name. The health improvement process could be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources, Mobilizing for Action through Planning and Partnerships (MAPP, developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include Asset Based Community Development model, National Public Health Performance Standards (NPHPS), Guide to Community Preventive Services, Healthy People 2030, County Health Rankings, or innovation processes such as design thinking. The process may be included within the health improvement plan itself or may be documented through a set of meeting minutes, presentations, or other written description of the process.		
a. A list of participating partners involved in the CHIP process. Participation must include: i. At least 2 organizations representing sectors other than public health. ii. At least 2 community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes.	**For required element a:** Participation includes active engagement to address community health issues or priorities. While the partnership could include other public health entities as appropriate for the jurisdiction (e.g., public health institutes, other health departments or military installation departments of public health located in/near the health department's jurisdiction), required element a(i) focuses on organizations that represent other sectors, which could include other governmental agencies (e.g., education, transportation, community development); not-for-profit groups, advocacy organizations, associations, or special interest groups related to health assessment priority areas (e.g., employment, housing); businesses; recreation organizations; or faith-based organizations. Members of this group may or may not be the same as members of the state/Tribal/community health assessment partnership. For required element a(ii), the documentation will include either partner organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes or individual community members. To empower individuals to participate in the improvement of health in their jurisdictions, the list of partners may also include community members. Individuals or organizations that represent populations with higher health risks or poorer health outcomes could include, for example: groups that represent minority health, historically excluded or marginalized population groups (e.g., communities of color or indigenous communities), aging populations (e.g., local, state, or regional aging networks and agencies), not-for profits, or civic groups representing specific subpopulations. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form—for example, to clarify who are community member representatives.)		

MEASURE 5.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
b. Review of information from the community health assessment.	**For required element b:** This could include, for example, meeting minutes demonstrating the state/Tribal/community health assessment was reviewed by the CHIP partnership, or other description describing how the health assessment findings were used in the health improvement planning process.		
c. Review of the causes of disproportionate health risks or health outcomes of specific populations.	**For required element c:** To determine which strategies to integrate into the CHIP in order to promote equitable opportunity for health for all, CHIP partnerships could review a range of social determinants of health, which may include structural determinants (or "root causes" of health inequities) and other causes for higher health risks among specific populations. This could include, for example, impacts of structural racism (e.g., redlining), disparities in the built environment, or inequitable distribution of social supports. Documentation demonstrating review of these determinants, could be, for example, a summary of partnership discussions or meeting minutes.		
d. Process used by participants to select priorities. The CHIP process must address the jurisdiction as described in the description of Standard 5.2.	**For required element d:** The intent of this required element is to describe the steps or tools used in the prioritization process. If the MAPP process is used, the description will include the specific steps and tools utilized. Tools to prioritize health issues could include, for example, nominal group or multi-voting techniques, affinity diagrams, or prioritization matrices. **Documentation Examples** Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, a memo describing the process, or an excerpt from the CHIP.		

MEASURE 5.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Adopt a community health improvement plan.

Purpose & Significance

The purpose of this measure is to assess the community health improvement plan (CHIP). The health improvement plan provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction. The plan reflects the results of a collaborative planning process that includes significant involvement by key sectors. Partners can use a health improvement plan to prioritize existing activities and set new priorities. The plan can serve as the basis for taking collective action and can facilitate collaborations.

MEASURE 5.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. A community health improvement plan (CHIP), which includes all of the following:	This may be referred to as a state health improvement plan, Tribal health improvement plan, or other name. A health improvement plan looks at population health across the jurisdiction. While programs in the health department may have program-specific plans, those plans do not fulfill the purpose of the health improvement plan to address the jurisdiction's priorities.		
a. At least two health priorities.	**For required element a:** The CHIP will designate two or more health priorities to be addressed collaboratively.		
b. Measurable objective(s) for each priority.	**For required element b:** Establishing one or more measurable objective(s) for each of the health priorities will enable the CHIP collaborative to determine if progress is being made towards addressing each priority. The objectives could be contained in another document.		
c. Improvement strategy(ies) or activity(ies) for each priority. i. Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it. ii. At least two of the strategies or activities must include a policy recommendation, one of which must be aimed at alleviating causes of health inequities.	**For required element c:** Improvement strategy(ies) or activity(ies) may be evidence-based, practice-based, promising practices, or may be innovative to meet the needs of the population. National guidance (e.g., the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2030) could be used as sources of strategies or activities, as appropriate. For i: Time-framed strategies or activities may be contained in another document, such as an annual work plan. If communities are using innovation processes (e.g., design thinking) or quality improvement processes, the strategies or activities may evolve as the community tests out solutions and makes adjustments. In those cases, the improvement strategies or activities included in the CHIP or workplan may describe the timelines for putting in place the process (e.g., that a group will be assembled to consider root causes and develop solutions to test), rather than the specific community actions. Designation of responsible parties may include, for example, assignments to staff or agreements between planning participants, stakeholders, other governmental agencies, or organizations. For this requirement, agreements do not need to be formal, such as an MOA or MOU. For ii: To achieve health priorities, the CHIP will include recommendations related to policy—either new policies or changes to existing policies. Policy recommendations could, for example, examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health or address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and climate change. While not all the strategies in the CHIP will entail policy recommendations (i.e., providing additional services or new health communications may be appropriate strategies), the CHIP will include at least two policy recommendations (e.g., introducing a healthy vending policy for schools). One of those policy recommendations is designed to alleviate causes of health inequities (e.g., changes in zoning laws). Policy recommendations may be developed by involving communities impacted by health inequities in the identification, development, and implementation of policy changes to improve conditions impacting their health.		

MEASURE 5.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.	**For required element d:** The assets and resources could be, but are not limited to, those identified as part of the CHA process. Community assets and resources could be anything that the jurisdiction could utilize to improve the health of the community. They could include, for example, skills of residents, state associations (e.g., service associations, professional associations), institutions (e.g., faith-based organizations, foundations, institutions of higher learning), recreational facilities, social capital, community resilience, or a strong business or arts community. These assets and resources will help the community address priority areas or implement strategies/activities. It is not necessary to include an asset or resource for each priority area. They may be included as part of the CHIP, as an addendum, or in a separate document (as long as the link to the CHIP is indicated).		
e. Description of the process used to track the status of the effort or results of the actions taken to implement CHIP strategies or activities. The CHIP must address the jurisdiction as described in the description of Standard 5.2.	**For required element e:** The health department or CHIP partnership defines the process that will be used to track the progress on CHIP strategies or activities. This may be included as part of the CHIP, as an addendum, or in a separate document.		

MEASURE 5.2.3 A:

Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to ensure that the strategies of the community health improvement plan are implemented, assessed, and revised as indicated by those assessments. Any plan is useful only when it is implemented and provides guidance for activities and resource allocation. Effective community health improvement plans should not be stagnant, but dynamic to reflect the evolving needs of the population served. Health departments should continuously work with multi-sector partnerships to evaluate and improve the community health improvement plan.

MEASURE 5.2.3 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
1. Community health improvement plan (CHIP) activity or strategy implemented. Examples must be from different health improvement plan priority areas. The Documentation Form must indicate to which CHIP strategy or activity the example applies. If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP. (Documentation must demonstrate the linkage between the activities or strategies and the prior CHIP. Although the prior CHIP may be more than 5 years old, the implementation must have occurred within 5 years.)	Implementation may be done by health department staff or other partners involved in the health improvement plan. Providing a tracking document or workplan for this requirement is **not** sufficient evidence. **Documentation Examples** Examples could include newspaper articles; photos demonstrating walking paths or no smoking signs; meeting minutes demonstrating the establishment of coalitions; or notes from meetings held with policy makers or partners.		

MEASURE 5.2.3 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 2 years
2. An annual review of progress made in implementing **all** strategies and activities in the community health improvement plan (CHIP). If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide (1) an annual review from a previous plan or (2) detailed plans for the annual review process.	The intent is to show a full review of progress on all CHIP strategies and activities. A review of one or a few strategies or activities would **not** meet the intent. If no progress has been made on a strategy or activity, this can be indicated in the report. **Documentation Examples** Documentation could include, for example, an annual report, a presentation shared with the CHIP partnership, or written summary to accompany a tracking document.		

MEASURE 5.2.3 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 2 years
3. Revisions to the community health improvement plan (CHIP) based on the review in Required Documentation 2 (above). If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide (1) revision of an earlier plan or (2) detailed plans for a revision process.	Strategies or activities may need revision based on, for example, a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. The revisions may be in the objectives, improvement strategies, planned activities, time-frames, targets, or assigned responsibilities listed in the plan. Developing changes in collaboration with partners and stakeholders involved in the planning process will strengthen the collaborative implementation of the health improvement plan.		

MEASURE 5.2.4 A:

FOUNDATIONAL CAPABILITY MEASURE

Address factors that contribute to specific populations' higher health risks and poorer health outcomes.

Purpose & Significance

The purpose of this measure is to assess the health department's intentional approach to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities. Differences in populations' health outcomes are well documented. Factors that contribute to these differences are many and include the lack of opportunities and resources, economic and political policies, structural racism and other forms of discrimination, and other aspects of a community that impact on individuals' and population's resilience. These differences in health outcomes require engagement of the community in strategies that develop community resources, capacity, and strength.

MEASURE 5.2.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or procedure	**Dated Within** 5 years
1. A policy or procedure that demonstrates how health equity is incorporated as a goal into the development of programs that serve the community.	The policy or procedure will show that the health department has established an approach to address differences in populations' health outcomes and the factors that contribute to differences, such as, lack of opportunities and resources, economic and political policies, discrimination, and other aspects of the community that influence health. The policy or procedure might address how factors that contribute to higher health risks are incorporated into processes, programs, and interventions. The policy or procedure could be organization-wide or could cover specific program(s). Characteristics of populations addressed in the policy or procedure could include, for example, social, racial, ethnic, cultural, sexual orientation, gender identity, linguistic characteristics (including non-English speaking populations), or individuals with disabilities. The policy or procedure might consider, for example, how the health department integrates more explicit language to build awareness of social determinants of health and health equity within its programming, health promotion, education, and communication strategies or in the health department's engagement with partner organizations and community stakeholders. Other methods might consider a deliberate approach within data collection and analysis to develop a deeper understanding of inequities or the root causes of disparities, such as, information on structural oppression and intersectionality (such as, structural racism, classism, exploitation, gender discrimination, heterosexism, ableism, cisgenderism, or xenophobia).		

MEASURE 5.2.4 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
2. Implementation of one strategy, in collaboration with stakeholders, partners, or the community, to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or inequities. The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community.	The example could be related to strategies in the state/Tribal/community health improvement plan, but it does **not** need to be. The example could follow the policy or procedure provided in Required Documentation 1, but evidence of this is **not** required. The health department does not need to have led the strategy, but the health department's role will be indicated to show how the department participated in implementing the strategy. Public health strategies implemented may address social change, social customs, policy, services, health communications (e.g., a campaign to promote antiracism or LGBTQ acceptance), level of community resilience, or the community environment which impact on health inequities. Implementation of the strategy is required; a plan would not be sufficient for this requirement. For example, policy changes could examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health. Policy changes considered may address the social and economic conditions that influence health equity including, for example, housing, transportation, education, job availability, neighborhood safety, and zoning. Collaboration with partners or stakeholders could include, for example, community or volunteer organizations, community hospitals, businesses and industries, academic institutions, or others including those who represent populations affected by health or social inequities. Tribal health departments may decide which subpopulations within the Tribal population or community that their public health initiatives are developed to address. Analyses that inform these decisions may be obtained from external sources such as Tribal Epidemiology Centers, state reports, or local sources. **Documentation Examples** Documentation could include, for example, a press release; report to the governing entity or the community; or other document that outlines efforts, achievements, or implementation updates.		

DOMAIN 6

Utilize legal and regulatory actions designed to improve and protect the public's health.

Domain 6 focuses on the role of public health departments in enforcing and fostering compliance with public health related regulations, executive orders, statutes, and other types of public health laws. Public health laws are key tools for health departments as they work to promote and protect the health of the population. Health department responsibilities related to public health laws do not start or stop with enforcement. Health departments have a role in educating regulated entities about the meaning, purpose, compliance requirements, and benefit of public health laws. Health departments also have a role in educating the public about laws and the importance of complying with them.

Public health laws influence the health of the entire population, such as environmental public health (e.g., food sanitation, lead inspection, drinking water treatment, clean air, waste-water disposal, and vector control), infectious disease (e.g., outbreak investigation, immunizations, infectious disease reporting requirements, quarantine, tuberculosis enforcement, and STI contact tracing), chronic disease (e.g., sales of tobacco products to youth, smoke-free ordinances, and adoption of bike lanes), and injury prevention (e.g., seat belt laws, helmet laws, speeding limits, and harm reduction).

The term "laws" as used in The Standards refers to ALL types of statutes, regulations, rules, executive orders, ordinances, case law, and codes that are applicable to the jurisdiction of the health department.

DOMAIN 6 INCLUDES **ONE** STANDARD		
Standard 6.1:	Promote compliance with public health laws.	
FOUNDATIONAL CAPABILITY MEASURE:		
Policy Development & Support	**6.1.4 A:**	Conduct enforcement actions.

STANDARD 6.1
Promote compliance with public health laws.

Public health laws impact all members of the community. Health departments have the responsibility to ensure just application of laws which promote opportunities for everyone to attain their full health potential. Health departments communicate with members of the community about the meaning behind the law, the purpose for the law, the benefits of the law, and compliance requirements. Communication efforts need to be culturally and linguistically appropriate to the audience, which could include the public, schools, civic organizations, businesses, other government units and agencies, and the medical community.

Health departments have a role in ensuring that public health laws are enforced. In some cases, the health department has the enforcement authority. In other cases, the health department works with those who have the legal authority to enforce the laws. When other state agencies, local departments, or levels of government have enforcement authority, the role of the health department is to collaborate, assist, and share information.

MEASURE 6.1.1 A:

Maintain knowledge of laws to promote and protect the public's health.

Purpose & Significance

The purpose of this measure is to assess how the health department ensures staff are trained on laws to promote and protect the public's health. Assuring that health department staff understand public health regulations is a key step in assuring proper enforcement.

MEASURE 6.1.1 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	2 years
1. Staff are trained on laws which they are programmatically required to enforce. Examples must be from two different enforcement areas. If the health department does not have enforcement authority, the examples must demonstrate staff are provided with training on how enforcement authorities are carried out by other agencies with enforcement authority to promote and protect health.	The intent of this requirement is training about a law that the health department or another entity enforces to protect or promote the health of the public (e.g., food codes or communicable disease reporting requirements). Training about laws the health department abides by or complies with, such as HIPAA, would **not** meet the intent of the requirement. The training may be provided by the health department or another entity, such as, a public health training institute, academic institution, or other agency. The training could include both general and specific aspects of public health law but will be relevant to the functions performed by staff. For example, an infectious disease nurse would be trained on laws pertaining to infectious disease reporting, rather than laws related to food program enforcement. Health departments that do not have regulatory enforcement responsibility still have a responsibility to maintain knowledge of laws that impact public health. For example, the school system may have the responsibility to ensure that all children entering kindergarten have had age-appropriate vaccinations. While the health department in this instance may not have enforcement authority, appropriate staff should be knowledgeable about how the relevant laws are carried out by other entities. Similarly, if the health department's sanitarians conduct inspections of properties, but the housing department or code enforcement is responsible for issuing enforcement actions (such as, notices of violations or orders), health department staff should be knowledgeable about relevant laws and how they are carried out. As another example, if the health department does not play a role in inspections or enforcement of food establishments, staff who interact with the public still need to be knowledgeable about which entities play those roles so that they can make appropriate referrals for community members who contact the health department about possible cases of food-borne illness. Attendance records are **not** required, but a description of who received the training (e.g., all health department staff or specific divisions) will be indicated. If it is not evident which staff received training, the documentation could be supplemented with an explanation in the Documentation Form. **Documentation Examples** Documentation could include, for example, in-person training materials, or recorded training modules.		

MEASURE 6.1.2 A:

Investigate complaints pertaining to public health regulations.

Purpose & Significance

The purpose of this measure is to assess the health department's responsiveness to complaints for matters related to regulations that protect and promote the public's health. Follow up of complaints should be conducted according to standard procedures and protocols. When health departments do not have enforcement authority, they can still play an important role by referring complaints to the appropriate entity.

MEASURE 6.1.2 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 protocols or 1 protocol that covers multiple enforcement areas	5 years
1. Protocols for complaint investigations, which include steps for follow-up. Examples must be from two different enforcement programs/areas or one protocol pertaining to multiple enforcement programs/areas. If the health department is not mandated to conduct complaint investigations, the protocol(s) must address the process to refer concerns or complaints to the appropriate agency with authority. If the health department has authority to conduct complaint investigations for only one program, one protocol must address that program and the other protocol must address the process to refer concerns or complaints to the appropriate agency with authority.	The intent of this requirement is to describe what happens after receiving complaints by the public, partners, or other organizations or agencies. Steps for follow up within the protocol could include, for example, initiating investigations by logging complaints received, conducting initial investigations with reports of findings, or generating communications to regulated entities of what is needed to achieve compliance (e.g., a notice of violations, letters, memos, or other issuances of findings). If the health department is not mandated to perform conduct complaint investigations, the protocol could include, for example, methods to communicate or coordinate with the agency(ies) with authority (e.g., correspondence, complaint handling referral systems, or other process to prompt follow up on concerns or complaints). Health departments without enforcement authority might not receive formal complaints from the public; therefore, a protocol for addressing informal concerns raised to health department staff would also be appropriate. This may be included within an MOU or agreement or may be less formal documentation.		

MEASURE 6.1.2 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Steps taken to investigate complaints pertaining to regulated entities. Examples must demonstrate that the protocol(s) provided in Required Documentation 1 were followed. Examples must be from two different enforcement programs/areas. If the health department is not mandated to conduct complaint investigations, examples must demonstrate how the health department communicated concerns or complaints to the agency(ies) with authority based on protocol(s) in Required Documentation 1. If the health department has authority for conduct complaint investigations for only one program, one example must address that program and the other must address communicating concerns or complaints to another agency with authority based on protocol(s) in Required Documentation 1.	The intent of this requirement is to show implementation of the protocol(s) to investigate complaints received (from Required Documentation 1). **Documentation Examples** Documentation could be, for example, copies of complaint investigation reports. If the health department is not mandated to perform inspections, documentation could be, for example, memos or other correspondence showing implementation of protocols to refer complaints or concerns for investigation, or coordination taken with other agencies during the investigation process.		

MEASURE 6.1.3 A:

Conduct and monitor inspection activities of regulated entities according to a schedule.

Purpose & Significance

The purpose of this measure is to assess the health department's adherence to guidelines on the frequency of inspection activities. Following a defined inspection frequency and tracking inspections performed can mitigate communicable diseases and other public health problems. If the health department has no enforcement authority, this measure does **not** apply.

MEASURE 6.1.3 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
1. Protocol/algorithm for scheduling inspections of regulated entities that defines the inspection frequency. The protocol/algorithm must be in programs/areas where the health department has authority to conduct an inspection of the regulated entity. Examples must be from two different inspection programs/areas. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement. If the health department is mandated to perform inspections in only one program/area, this will be indicated to PHAB and only one example is needed for this requirement.	The health department may select the areas or programs. In some cases, frequency or schedule for inspections are defined by law. In other cases, the department may provide a risk analysis method in a protocol or an algorithm, which guides the frequency and scheduling of inspections of regulated entities. This could include, for example, rules requiring restaurant inspections on a specified schedule or a schedule for return inspections after a violation. The frequency may be variable, for example, set by risk level among food establishments. The protocols could also address methods to perform inspections equitably or using an equity lens by describing, for example, steps to ensure investigations receive equal response time or follow up, regardless of the location's median income or poverty level; or investigation processes that work with people who are disenfranchised, unempowered, or under-resourced. **Documentation Examples** Documentation could include, for example, a protocol defining inspection frequencies or a schedule of inspection frequencies.		

MEASURE 6.1.3 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. A database or log of inspection reports that meet inspection frequencies, as defined in Required Documentation 1. The database or log must at a minimum include:	The intent of this requirement is to demonstrate tracking of inspections performed according to the frequency defined in Required Documentation 1 in the form of a database or log of multiple inspection reports (as opposed to a single report) that includes dates of inspections performed, the schedule indicating dates of future inspections, and actions taken based on findings. There may be variations within the log, depending on the type of facility (e.g., food establishments may require different timeframes for follow up based on risk level) or type of violation (e.g., critical or non-critical), as timelines or actions could differ.		
a. Dates that inspections occurred.	**For required element a:** The database or log will include dates when inspections were performed.		
b. Dates or timeframes when future inspections are scheduled.	**For required element b:** The intent of this required element is to demonstrate the schedule for future inspections, which could be a set date or timeframe (e.g., "in 2 weeks" or "in 1 month" or "in quarter 3").		
c. Actions taken based on inspection findings. This documentation of inspections must relate to one of the enforcement programs/areas that were provided in Required Documentation 1 above. If the health department has **no** enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	**For required element c:** Actions taken based on inspection findings could include, for example, approval or license renewal or steps to address violations, such as follow up or reinspection. **Documentation Examples** Documentation could include, for example, screen shots of a database with fields corresponding to required elements a-c visible, or tracking logs maintained in a spreadsheet.		

MEASURE 6.1.4 A:

FOUNDATIONAL CAPABILITY MEASURE

Conduct enforcement actions.

Purpose & Significance

The purpose of this measure is to assess the health department's standardized approach to consistently implement enforcement actions. Regulated entities require information on how to achieve compliance with public health laws. Health departments should consider cultural, linguistic, or other communication considerations to improve compliance. If the health department has no enforcement authority, this measure does **not** apply.

MEASURE 6.1.4 A: Required Documentation 1	Guidance	Number of Examples	Dated Within
		2 protocols	5 years
1. Protocol for enforcement. At least one of the two examples must address infectious illness, if the health department has enforcement authority for at least one infectious illness. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to demonstrate how the health department operationalizes legal authorities to conduct enforcement activities (which were provided in the health department's application). Codes alone are **not** sufficient unless the code includes steps involved in operationalizing enforcement activities. Infectious illness examples could include, for example, enforcement of isolation and quarantine laws (e.g., infectious TB, or Ebola), or infectious agents associated with foodborne illness originating from a regulated entity (e.g., salmonella, norovirus, or campylobacter). Non-infectious areas could include, for example, Legionnaires', lead, cancer clusters, seat belt use, sale of tobacco products to minors, or clean indoor air laws. The protocol might consider potential equity impacts or ethical implications of enforcement activities to protect populations who are at risk of harm or collateral consequences, such as, protecting tenants reporting unhabitable living conditions from being evicted or providing alternate housing; preventing inspection of facilities from being used for deportation raids; or protecting whistleblowers from retaliation. The health department could also consider inequitable enforcement practices as a cause for disparities if, for example, people of color or low-income individuals receive a disproportionate level of fines or violations or if there is underenforcement in certain areas.		

MEASURE 6.1.4 A: Required Documentation 2	Guidance	Number of Examples	Dated Within
		2 examples	5 years
2. Implementation of enforcement protocol from Required Documentation 1. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to show implementation of each of the two protocols for enforcement submitted in Required Documentation 1, above. **Documentation Examples** Documentation could be, for example, enforcement documents or logs, case reports, or minutes of meetings that detail enforcement actions taken.		

MEASURE 6.1.4 A:	Guidance	Number of Examples	Dated Within
Required Documentation 3		2 examples	5 years
3. Information provided to regulated entities about their responsibilities related to public health laws. Documentation must include both the information provided **and** description of its distribution. (If the description of distribution is not evident in the example, it could be indicated in the Documentation Form.) One of the examples must demonstrate consideration of cultural humility, literacy, or other special communication considerations. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	The information to regulated entities could be, for example, providing information or education to food service or pool operators on how to comply with safety requirements or regulations. Cultural humility, literacy, or other special considerations could include, for example, providing information in other languages, using plain language or pictures, using interpreters or staff familiar with cultural backgrounds of regulated entities. This could include, for example, use of interpreters to communicate regulations or cultural considerations taken into account while providing education to food establishments, or engaging staff familiar with Islamic law and customs in Halal food preparation or Jewish laws and traditions related to Kosher food preparation. The documentation could be supplemented with a description in the Documentation Form of how the consideration of cultural humility, literacy, or other special communication considerations were accomplished. **Documentation Examples** Documentation could be, for example, a set of FAQs sent to regulated entities, newsletters, training sessions, public meetings, documentation of technical assistance and information (provided through email or phone logs), pamphlets, posters, press releases, or social media. If it is not evident within the documentation, the description of distribution may be included on the Documentation Form.		

MEASURE 6.1.4 A: **Required Documentation 4**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
4. Hearings, meetings, or other official communications with regulated entities regarding a compliance plan. Examples must include any resulting compliance plans. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	The regulated entity, based on the law, could be an organization, business, or individual. The compliance plan has no specific format and will be determined by law or health department protocol. The compliance plan may have initiated from a routine inspection or a complaint. **Documentation Examples** Documentation could be, for example, minutes of an official meeting with the regulated entity that describe the compliance plan, or an enforcement letter with accompanying compliance plan sent to the regulated entity.		

MEASURE 6.1.5 A:

Coordinate notification of enforcement actions among appropriate agencies.

Purpose & Significance

The purpose of this measure is to assess the health department's communication with other agencies about enforcement activities. It is important that the health department shares information concerning enforcement actions or any resulting follow-up with other agencies that have a role in educating or providing follow-up with the regulated entity. If the health department has no enforcement authority, this measure does **not** apply.

MEASURE 6.1.5 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 protocols or 1 protocol that covers multiple enforcement programs/areas	5 years
1. A communication protocol for how the health department notifies another agency(ies) of enforcement actions. The health department must provide examples from two different enforcement programs/areas or a protocol that covers multiple enforcement programs/areas. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to inform partners of enforcement actions taken by the health department. For example, the protocol to inform other agencies could be to send written correspondence notifying building and housing or code enforcement, or to the legal department (if located outside of the health department) regarding enforcement actions the health department plans to take. An example of an enforcement program specific protocol could include, for example, sending written correspondence notifying the housing authority that the health department plans to take enforcement actions when issuing a legal notice. A protocol that covers multiple enforcement programs/areas could either address a minimum of two enforcement programs/areas or could be a comprehensive protocol covering all interagency communications. A comprehensive protocol could, for example, provide guidelines that will be followed for any notification to other agencies regarding enforcement actions.		

MEASURE 6.1.5 A:	Guidance	Number of Examples	Dated Within
Required Documentation 2		1 example	5 years
2. Notification to another agency of enforcement action(s). Documentation must demonstrate that protocols in Required Documentation 1 were followed. If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.	Documentation could include, for example, notifying other agencies through written correspondence (e.g., memos or emails), public presentations, reports, or documented conference calls.		

MEASURE 6.1.6 A:

Inform the public about enforcement activities.

Purpose & Significance

The purpose of this measure is to assess the health department's communication with the public to foster awareness of enforcement activities. It is important that the health department share enforcement information with the public so community members can make decisions or alter their behavior, based on the information.

MEASURE 6.1.6 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 protocols or 1 protocol that covers multiple enforcement programs/areas	**Dated Within** 5 years
1. A protocol for notifying the public of actions they need to take or not take based on enforcement activities. The health department must provide examples from two different enforcement programs/areas or a protocol that covers multiple enforcement programs/areas. If the health department has **no** enforcement authority, the protocol must address how the health department shares information with the public about the enforcement activities of other agencies so that the public is informed of actions they should or should not take.	The protocol may be in parts to address multiple enforcement actions, it may be a single comprehensive protocol for notifying the public concerning enforcement actions, or it may be within another protocol such as risk communications. The process of notifying the public could be, for example, posting notices of enforcement actions to a website or social media, minutes of public meetings, or press releases. If the health department has no enforcement authority, the protocol could address ways the health department has helped the agency with authority to facilitate communicating enforcement actions to the public. This could include, for example, sharing social media posts or website posts to help the entity with enforcement authority to disseminate information to the public. The intent is **not** to prescribe how other agencies should notify the public **but instead** to strengthen a collaborative working relationship. The protocol could be included in an MOU or MOA with another agency or may be less formal.		

MEASURE 6.1.6 A:	Guidance	Number of Examples	Dated Within
Required Documentation 2		1 example	5 years
2. Notification to the public of enforcement activities, which demonstrates consideration of cultural humility, literacy, or other special communication considerations. Documentation must demonstrate that protocols in Required Documentation 1 were followed. If the health department has no enforcement authority, the health department must provide an example of communicating the enforcement actions of other entities to the public (based on Required Documentation 1).	The intent of this requirement is to demonstrate the health department's implementation of protocols from Required Documentation 1. Examples of notifications to the public could include, for example, restaurant inspection violations, emission violations, and inspections of public facilities (e.g., public swimming pools). The protocol could address notifying the public by, for example, posting enforcement actions (e.g., closures or inspection reports) to its website; placarding properties to warn the public the premises are unsafe (e.g., based on lead inspection findings, nuisances, or other hazards); signs warning public swimming pools are unsafe; social media posts; or press releases. Cultural humility, literacy, or other special considerations could include, for example, the language(s) used to communicate a message, wording or graphics to support understanding among populations with low literacy levels, or use of TTY/TDD technology or sign language interpreters. Other considerations could address cultural humility, which considers the approach for tailoring communication messages in the context of underlying values, perceptions, and beliefs that could influence understanding and behavior based on the information shared. The Documentation Form may be used to describe how consideration of cultural humility, literacy, or other special communication considerations were accomplished. If another entity is responsible for enforcement, the health department could demonstrate sharing information with the public through, for example, web posts, social media, or other methods.		

MEASURE 6.1.7 A:

Identify and implement improvement opportunities to increase compliance.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to improve compliance by analyzing complaints, enforcement activities, and compliance rates; identifying improvement opportunities and implementing changes; and providing information to the public about the purpose of regulations. Understanding trends can help in employing preventive measures, pursuing opportunities for improvement in enforcement activities, and providing follow-up education. Assessing patterns and trends within the jurisdiction can lead to increased communication and foster collaboration with other enforcement agencies and partners to improve compliance. Another strategy for improving compliance is ensuring the public is aware of the purpose and value of public health regulations.

MEASURE 6.1.7 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Assessment of enforcement programs, which must include:	The intent of this requirement is to show how the health department has assessed enforcement activities within the jurisdiction to identify opportunities for improvements that could foster increased awareness among the public, strengthen collaborative relationships or communication with other enforcement agencies, or improve compliance among regulated entities.		
a. A summary of patterns or trends in complaints, enforcement activities, or compliance.	**For required element a:** The summary could describe, for example, what are the most common types of enforcement activities, whether complaints are happening more frequently in certain neighborhoods, or whether compliance has increased or decreased compared to previous years. Patterns or trends could be related to the type of violation, enforcement actions taken, geographic location (e.g., accumulation of solid waste and related enforcement activities in one location), or other factors. For example, patterns or trends for food program inspection activities could include the most common types of violation with the percent of facilities inspected that had the violation. As another example, a summary of nuisance complaints by type (e.g., sewage and housing complaints) and geographic area could identify patterns. A list of enforcement activities or complaints would **not** meet the intent of this required element.		
b. What worked well. c. What issues arose.	**For required elements b and c:** The intent of these required elements is to evaluate the health department's processes (**not** that of the regulated entity), which could be related to the health department's methods to provide education or enforcement to achieve compliance. The intent is **not** to show what worked well or was problematic for a single investigation, **but instead** to evaluate the enforcement program's activities and processes, based on a review of its patterns or trends.		

MEASURE 6.1.7 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
d. Recommended changes in investigation, enforcement procedures, or other actions to improve compliance. The examples must be from two different enforcement programs. If the department operates an enforcement program that is out of compliance with state law or is under sanctions or a performance improvement plan, then one of the examples must be from that program. If the health department has no enforcement authority, it must be indicated to PHAB and **no** documentation is needed for this requirement. If the health department has authority for only one enforcement program, the health department must submit only one example from that program and must indicate in the Documentation Form that they only have enforcement authority for one program.	**For required element d:** Changes or improvements related to internal processes could include, for example, improving efficiency by reassigning staff based on geographic patterns or trends (e.g., assigning staff and adjusting scheduling based on zip codes), or identifying a need for improved communication with regulated entities on how to achieve compliance based on repeated violations. Examples could also reveal opportunities to work with regulated entities in a more culturally or linguistically appropriate manner, if violations are occurring based on barriers to understanding public health laws or regulations.		

MEASURE 6.1.7 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Changes to investigation procedures, enforcement procedures, or other actions taken to improve compliance. If the health department has no enforcement authority, it must be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is to demonstrate improvements made to promote compliance. Improvement could be related to investigations, enforcement, or actions taken to prevent regulated entities from being out of compliance. Both examples could be from the same program area or different program areas. Examples could include, for example, revising the algorithm for inspections, launching an educational campaign among regulated entities based on a pattern of non-compliance issues, or providing information or training to regulated entities or staff to improve compliance in a culturally or linguistically appropriate manner. Examples may demonstrate the recommended changes listed in Required Documentation 1, required element d, above, or may relate to other implemented changes.		

MEASURE 6.1.7 A: Required Documentation 3	Guidance	Number of Examples 2 examples	Dated Within 5 years
3. Communication provided to the public on the purpose of public health regulations. The example must include evidence that the information was shared or distributed by the health department, regardless of the entity that created the communication. Examples must be from two different enforcement areas.	The intent of this requirement is that the health department demonstrate fostering awareness of the purpose or value of public health regulations to promote and protect health for the purpose of increasing compliance. Ensuring the public is aware of the purpose and value of public health regulations may be one of the methods used to improve compliance. Communications with the public could be about the purpose of, for example, tobacco-free ordinances, restaurant inspections, or public health nuisance regulations. Health departments that do not have regulatory enforcement responsibility still have a responsibility to foster awareness and knowledge of laws that impact the public's health. For example, the school system may have the responsibility to ensure that all children entering kindergarten have had age-appropriate vaccinations. In this instance, the health department could provide education to the public on the purpose or importance of immunization laws. The health department can work with other partners (e.g., community-based organizations, other governmental agencies, policymakers, or governing entities) to produce the communication. In some instances, communications may have greater impact if they are disseminated by, or have the logo of, those other organizations. The health department can provide documentation produced by other organizations if the health department's role in helping disseminate is clear, either in the example or in an explanation in the Documentation Form. For example, the health department could retweet a message from the police department about the importance of tobacco enforcement. **Documentation Examples** Documentation could include, for example, a set of FAQs on the health department's website, newsletters, public meeting minutes, posters, press releases, or social media.		

DOMAIN 7

Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.

Domain 7 focuses on the health department's role in assuring an effective system that enables equitable access to the individual services and care that are needed to be healthy. This domain does not assume the health department is responsible for providing individual services, but it has a role in ensuring the population has access to needed services. In order to ensure that the population has access to these services, health departments engage in activities to assess, develop, and improve the systems that support the delivery of those services and thus meet the collective needs of many individuals. While health care focuses on individuals, public health focuses on populations. Influencing access to and linkage with services which meet the needs of the "whole person" requires broad engagement across sectors including health, social services, and others to leverage community assets towards meeting community needs.

DOMAIN 7 INCLUDES **TWO** STANDARDS		
Standard 7.1:	Engage with partners in the health care system to assess and improve health service availability.	
Standard 7.2:	Connect the population to services that support the whole person.	
FOUNDATIONAL CAPABILITY MEASURE:		
Community Partnership Development	**7.2.1 A:**	Collaborate with other sectors to improve access to social services.

STANDARD 7.1

Engage with partners in the health care system to assess and improve health service availability.

As part of the health department's health strategist role, it should engage with a variety of partners in health delivery systems to assess and address gaps and barriers in accessing needed health services, including behavioral health and primary care; provide timely and accurate information to the health care system and community on access and linkage to clinical care; identify populations who are under-served or experience barriers to health care; and develop and promote strategies to address the identified systemic barriers.

MEASURE 7.1.1 A:

Engage with health care delivery system partners to assess access to health care services.

Purpose & Significance

The purpose of this measure is to assess the health department's participation in a collaborative process to develop an understanding of the population's access to needed health care services, including behavioral health and primary care. Collaborative efforts are required to assess the health care needs of the population of the Tribe, state, or community and to understand the systemic barriers that may make it difficult for some populations to access care. These data can be useful in developing strategies or seeking support to expand services.

MEASURE 7.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 assessment	Dated Within 5 years
1. A collaborative assessment of access to health care that includes the following:	The intent of this requirement is that the health department collaborate with health care, behavioral health, and others to assess the availability of health care services within the health department's jurisdiction. The collaborative assessment addresses the availability of health care services for planning purposes. While the assessment will include behavioral health and primary care, it could also include other services (e.g., oral care, clinical preventive services, Emergency Medical Services (EMS), emergency departments, urgent care, occupational medicine, specialty ambulatory care, inpatient care, diabetic care, or HIV health services). The collaborative assessment of access to care may be part of the state/Tribal/community health assessment or a separate assessment. Multiple assessments may be provided to address the required elements, as needed. The assessment could be conducted at a regional level, for example, if there are limited care providers within the jurisdiction served by the health department.		
a. A list of partners that were involved, which must include primary care and behavioral health providers.	**For required element a:** The health department could lead or be a member of the collaborative group. The group could be the same as the one that developed the state/Tribal/community health assessment or state/Tribal/community health improvement plan. In addition to engaging members of the health care and behavioral health system(s), collaborative partners could include, for example, academic institutions, non-profits, other agencies (such as, community development), businesses or employers, health insurance companies, communities of color, Tribes, low-income workers, military installations, correctional agencies, specific populations who may lack health care or experience barriers to service (e.g., individuals with disabilities, non-English speaking, or other populations with special needs), social service organizations, or public health trained clinicians who understand both the clinical aspects of direct-service provision as well as health care delivery systems to align services for more effective impact. For Tribal health departments, it could include, for example, Indian Health Service, other Tribal programs and departments, and individuals representing communities that experience barriers to services (e.g., distance from service, transportation barriers).		
b. Review of data on populations who lack access or experience barriers to care.	**For required element b:** The system of care may not be well designed to serve populations based on, for example, age (e.g., teenagers or older adults), ethnicity, geographic location, health insurance status, educational level obtained, intellectual or physical disabilities, individuals who face discrimination (e.g., marriage inequality), or special health service needs (e.g., people who are pregnant or individuals with diabetes). Information about systematic barriers could be obtained from, for example, surveys of particular population groups or secondary sources (e.g., emergency department admissions or population insurance status data). The partners involved in the assessment could use existing data sources or they could collect new data. If collecting new data, the partners could consider broadening engagement by, for example, using translators or translating data collection forms or surveys in multiple languages, include simplified wording and plain language, visual aids, or use of real-life scenarios appropriate to the priority audience.		

MEASURE 7.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 assessment	**Dated Within** 5 years
c. Review of data on the availability and gaps in services.	**For required element c:** Assessment of services could include, for example, the capacity and geographic distribution of providers (e.g., patient/provider ratios or those accepting new clients); or services that are not widely available (e.g., services with long wait times to get appointments or areas within the jurisdiction with limited or no providers). Data used in the analysis may include secondary sources, such as, HRSA Area Health Resources Files, AHRQ Social Determinants of Health Database, CDC PLACES data portal, or US Census American Community Survey.		
d. Conclusions drawn about the causes of barriers to access to care. Primary care and behavioral health care must each be considered within the assessment.	**For required element d:** Conclusions drawn based on data about the availability (required element c) or barriers (required element b) could relate to, for example, the capacity and distribution of health care providers. Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications for the community (e.g., reviewing prevalence data and demographic trends to determine which health conditions pose the biggest threat), drawing inferences about the relationship between different variables (e.g., a connection between self-reported lack of access to dental care and data on providers who will not accept Medicaid or Medicare), or making hypotheses about potential causes of the findings (e.g., a lack of access to obstetric services may be caused by lower revenue or reimbursement rates forcing hospitals to limit or eliminate services). The conclusions could be based on statistical analysis demonstrating causal relationships, but they do **not** need to. Barriers could also include, for example, lack of insurance or underinsurance, lack of transportation to care, limited access to providers who speak languages other than English, travel distance in rural areas, limited-service hours of health care, or stigma associated with seeking behavioral health services. The conclusions could explore the root causes of those barriers, which may be related to systems, structures, social determinants of health, or aspects of social or environmental justice. For example, social and economic disadvantage, racism, under/unemployment, unsafe or insecure employment conditions, and social exclusion negatively influence health status and access to care. Barriers among specific populations could be caused by lack of trust in the health care system or providers leading to delayed routine medical services or screenings. **Documentation Examples** Documentation could be, for example, a report or excerpt of the state/Tribal/community health assessment that specifically addresses access to care, or a separate assessment process that focuses on access to health care. The list of partners may be included in the assessment or in meeting minutes.		

MEASURE 7.1.2 A:

Implement and evaluate strategies to improve access to health care services.

Purpose & Significance

The purpose of this measure is to assess the health department's collaborative efforts to develop and implement strategies to increase access to health care for those who experience barriers to services while ensuring cultural humility, language, or literacy are addressed. Factors that contribute to poor access to services are varied. A partnership with other organizations and agencies provides the opportunity to address multiple factors and coordinate strategies.

MEASURE 7.1.2 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Collaborative implementation of a strategy to assist the population in obtaining health care services.	The health department does **not** need to have convened or led the collaborative process, but the health department's role will be indicated to show how the department participated in implementing strategies. The collaboration could include working with, for example, community-based organizations, primary care providers, behavioral health providers, oral health providers, community health workers, or Community Health Representatives (CHRs). In agencies with multiple divisions (e.g., superagency), the collaboration could be between public health and another division or department (i.e., between public health and behavioral health). General planning, such as a one-time discussion would **not** meet the intent of the requirement, which is to show collaborative implementation. Examples could include documentation that indicates the health department's role in the following: ▪ Building relationships with payers and healthcare providers, including the sharing of data across partners to foster health and well-being. ▪ Coordinating and integrating categorically funded behavioral, public health, and primary care services. ▪ Collaborating with organizations representing different cultural groups on a campaign to reduce stigma associated with seeking behavioral health services. ▪ Increasing the availability or methods to access timely care through telehealth services or other mechanisms. ▪ Arranging for transportation mechanisms or coordination of services, for example, for individuals who are home bound. ▪ Collaborating with partners on strategies to use community health workers, community health representatives, patient navigators, traditional healers, Clan Mothers, or members of the community. ▪ Establishing a continuum of care model, for example, for substance abuse by working with behavioral health or first responders. ▪ Achieving policy changes or additional resources to facilitate access (e.g., Medicaid expansion programs or expansion of service availability among those eligible for Federally Qualified Health Center (FQHC) services). Strategies may consider those who have barriers accessing care based on the assessment from Measure 7.1.1 (e.g., individuals who are older, have disabilities, or experience cultural, language, low literacy, or other barriers). **Documentation Examples** Documentation could be, for example, meeting minutes documenting strategies that have been implemented or an excerpt of a report or other document summarizing strategies that were implemented.		

MEASURE 7.1.2 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. Evaluation findings of a strategy to increase access to health care, which must include collection of feedback from patient population(s) who were the focus of the strategy. The evaluation must relate to one of the examples in Required Documentation 1.	The intent of this requirement is that feedback be gathered from patient populations who were the focus for the strategy—in other words from those with lived experiences related to barriers to obtaining care whom the strategy was intended to assist. Gathering data only from partners (e.g., groups representing patients or service providers) would **not** meet the intent of this requirement. The health department may or may not be the entity to conduct the evaluation, as long as the health department participated in the implementation of the strategy. Findings that summarize the results of the evaluation will be provided. The feedback collected from individuals is **not** required. The Documentation Form may be used to describe who participated in the evaluation. The evaluation process may occur as part of the state/Tribal/community health improvement plan, or evaluation of health equity initiatives, or separate process. The evaluation may be a process evaluation (i.e., one that is seeking to improve the implementation of the initiative) or an impact evaluation (i.e., one that is seeking to understand whether the initiative met its goals). In addition to collecting feedback from at least one population that was the focus of the strategy, the evaluation could examine topics that include, for example, out-of-pocket or other cost reductions, timeliness or availability of appointments, increased service utilization, or ultimately improved health status or outcomes. **Documentation Examples** Documentation could include, for example, an evaluation summary, report, meeting minutes, or a presentation showing evaluation findings about needed process changes or the impact of strategies on meeting intended goals.		

MEASURE 7.1.3 S:

Establish or improve systems to facilitate availability of high-quality health care.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** efforts to improve existing systems or create new systems that are designed to improve the availability of high-quality health care for all. State health departments play an important role in establishing and improving mechanisms and systems to ensure access to health care across local jurisdictional boundaries. State health departments should be knowledgeable about health care financing systems and other system-wide initiatives in order to champion policy changes that impact access to high-quality care.

MEASURE 7.1.3 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 example	5 years

1. Effort to develop or improve systems for ensuring the availability of health care.

The documentation **cannot** be the same examples provided for Measure 7.1.2, but could demonstrate additional efforts to continue to improve systems or policies related to those examples previously provided.

The intent of this requirement is that the state health department demonstrates how it has engaged in efforts to change policies or systems in order to enhance availability of health care. The example could be of an effort that is still ongoing or did not meet the intended goals.

While Measure 7.1.2 focuses on initiatives to increase access to care, this measure recognizes state health departments' position in being able to influence state-level levers to ensure that systems are designed to make high-quality health care available to all. This may be through statewide initiatives related to, for example, financing, quality monitoring, delivery systems, or the healthcare workforce.

State health departments could engage in these efforts collaboratively and do **not** need to be the lead, but the health department's role will be indicated to show how the department participated. Efforts could be demonstrated by working in collaboration with other parts of an umbrella agency, if, for example, the state office of human services, Medicaid or Medicare, is part of the same agency as the health department. Collaboration could also include, for example, state health insurance plans or health care financers [e.g., Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs), Medicaid or Medicare]. General planning, such as a one-time discussion, would **not** meet the intent of the requirement which is to show engagement in the effort.

Efforts could include strategies, changes, or policies related to, for example, cost-sharing, reimbursement mechanisms to value outcomes (rather than volume), transparency on pricing or services covered under insurance, cost control strategies, mental health parity, reduction of waste and unnecessary costs through service efficiencies across providers, increased reimbursement for preventative care, all-payer claims databases or other data-sharing systems across sectors to facilitate information sharing and planning, coordinated service delivery (e.g., community health worker programming, medical homes, patient navigation systems, or integrated care models), quality monitoring or value-based payment, workforce development initiatives (e.g., tuition reimbursement or other efforts to incentivize care in underserved areas), efforts to further health information exchange and interoperability, or continuum of care models (e.g., to coordinate with behavioral health and first responders on a continuum of services related to substance abuse).

Documentation Examples

Documentation could include, for example, reports or other summaries of activities, meeting minutes showing activities, testimony, presentations, grant applications, or grant implementation.

STANDARD 7.2

Connect the population to services that support the whole person.

There are many factors that can contribute to lack of access to health care and social services, including insurance status, transportation, travel distance, availability of a regular source of care, wait time for appointments, and office wait times. Social conditions also influence access to services, as systems are not well designed to meet the needs of individuals with lower literacy or health literacy levels, who speak languages other than English, who may not trust the care system due to past experiences, or who lack flexibility in employment leave. Once the barriers and gaps in service are identified, strategies may be developed and implemented to address them and mobilize community assets towards establishing linkages and integrations in services to promote access to support the well-being of the whole person (including behavioral health, social services, health care, and other needs). Health departments also play a role in planning for continuity of access to care during service disruptions, such as natural disasters.

MEASURE 7.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Collaborate with other sectors to improve access to social services.

Purpose & Significance

The purpose of this measure is to assess the health department's collaborative efforts to develop and implement multisector or system strategies to increase access to social services, which may be achieved by integrating health care and social services. As health strategists, health departments play an integral role in engaging across sectors to improve the health of the community by developing systems and interventions that foster health and well-being of the whole person. Factors that contribute to poor access to services are varied, requiring engagement and mobilization of multiple sectors. A partnership with other organizations and agencies provides the opportunity to address multiple factors and coordinate strategies.

MEASURE 7.2.1 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Multi-sector implementation of an effort to improve access to social services or to integrate social services and health care.	The intent of this requirement is to demonstrate how the health department, in partnership with others (e.g., healthcare, social service, and behavioral health providers), has implemented strategies or systems of care designed to connect clients to needed resources. This could include, for example, coordinating services for populations who are vulnerable or at risk through data exchange systems designed to identify individuals with high service utilization, working with providers to develop systems to assess social needs of clients, setting up systems for referrals, or developing coordination systems to integrate social service, behavioral health, public health, and primary care services. The health department does **not** need to have convened or led the collaborative process, but the health department's role will be indicated to show how the department participated in implementing strategies. Examples that focus on the needs of the whole person might address prevention or upstream services, or integration of physical and behavioral health concepts. A one-time discussion would **not** meet the intent of the requirement which is to show collaborative implementation of efforts. Efforts could include, for example, implementation or collaborative plans for implementation, such as a submitted grant application or executed MOU. The Documentation Form could provide an overview describing how the documentation illustrates the collaborative efforts to improve access. **Documentation Examples** Documentation could include, for example: ▪ A signed Memoranda of Understanding (MOU) between partners that lists activities, responsibilities, scope of work, and timelines. ▪ A documented cooperative system of referral between partners that shows the methods used to link individuals with needed health care and social services. ▪ Integration of screenings for adverse childhood experiences (ACEs) or social determinants of health into primary care visits, or prioritization to focus on the most vulnerable or disparate subpopulations and their critical needs. ▪ Documentation of outreach activities, such as use of social media campaigns, PSAs, or marketing tools to reach underserved diverse communities as part of WIC outreach, for example, coordinated with partners to ensure that people can obtain the services they need. ▪ Press releases about addressing barriers to access needed social services by collaborating with departments of transportation to establish new or rural routes or accommodations for those with disabilities. ▪ Meeting minutes describing systems developed with partners to facilitate data sharing to identify populations who are vulnerable or at risk for the purposes of coordinating service programs (e.g., common intake form) or co-location (e.g., social services, WIC, immunizations, and lead testing) to optimize access.		

MEASURE 7.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
	▪ Documentation of coordinating alerts among providers for use when transferring patients with diseases of concern or high transmissibility to reduce transmission among staff and other patients or residents in congregate living arrangements. ▪ Project reports about collaborating with partners to establish mechanisms to facilitate utilization of social, behavioral, transportation, and other services among WIC clients or provide new services to WIC-eligible clients to meet basic needs, such as, partnerships with farmers market vendors to accept vouchers. ▪ Grant applications submitted by community partnerships that address increased access to health care and social services. ▪ Subcontracts in the community to deliver health care and social services in convenient and accessible locations. ▪ Program/work plans documenting strategies that improve access to social services that were developed collaboratively and include roles and timelines for activities. ▪ Documentation of transportation programs that improve access to social services or transport between long-term care, nursing homes, and hospital stays.		

MEASURE 7.2.2 A:

Collaborate with other sectors to ensure access to care during service disruptions.

Purpose & Significance

The purpose of this measure is to assess the health department's collaborative efforts to develop strategies to ensure continuity to access to health care or social services during emergencies or other service disruptions. Health departments have a key role to play in collaborating with partners to ensure the population maintains access to health care or social services when circumstances (e.g., outbreaks, natural disasters, or temporary closures of facilities) might temporarily disrupt that access.

MEASURE 7.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Collaborative strategy to ensure continuity of access to needed care during service disruptions.	The intent of this requirement is to demonstrate how the health department collaboratively contributes to ensuring continuity of access to health care or social services in the community in the event of a disaster or disruptions to the delivery of services. While other governmental organizations may have primary responsibilities to coordinate emergency services, the health department's role may be to support other governmental agencies in ensuring access to health care and social services, or it may have a specific assigned role under the emergency operations plan (e.g., ensure continuity of access to services for sheltered populations). Continuity of the health department's services or operation would **not** meet the intent of the requirement. The documentation could be of a strategy that was implemented or of the specific plans of a strategy to be used in the future. Collaborative strategies may be contained within the emergency operations plan or separate document. General planning, such as a one-time discussion, would **not** meet the intent of this requirement. Strategies could include, for example, establishing systems of care at alternate locations as a result of an emergency (e.g., outbreak, severe weather event, or catastrophic damage to the facilities of a major health care provider); ensuring access to prescription drugs if patients are temporarily unable to access pharmacies; creating alternate strategies for families to receive food support if meal programs at schools are disrupted; contingency planning to address the short-term access challenges resulting from a loss of a hospital, clinic, or service (e.g., planning for women's health services if Planned Parenthood or other providers discontinue services); or providing assistance with housing in the face of rising unemployment rates due to an epidemic or emergency. **Documentation Examples** Documentation could be, for example, reports or other summaries of strategies planned or implemented; meeting minutes showing collaborative planning of strategies; work plans developed collaboratively with established roles; MOUs or other agreements; submitted grant applications or grant implementation; or an excerpt of the emergency operations plan.		

DOMAIN 8

Build and support a diverse and skilled public health workforce.

Domain 8 focuses on the need for health departments to strategically support the development of a competent workforce to perform public health functions. A multi-disciplinary workforce that is matched to the specific community being served facilitates the ability to address the population's public health issues and advance equity. Strategic workforce development aligns staff recruitment, development, and retention with the health department's mission, goals, and strategic priorities.

DOMAIN 8 INCLUDES **TWO** STANDARDS		
Standard 8.1:	Encourage the development and recruitment of qualified public health workers.	
Standard 8.2:	Build a competent public health workforce and leadership that practices cultural humility.	
FOUNDATIONAL CAPABILITY MEASURES:		
Organizational Competencies	**8.1.2 A:**	Recruit a qualified and diverse health department workforce.
	8.2.1 A:	Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.
	8.2.2 A:	Provide professional and career development opportunities for all staff.

STANDARD 8.1

Encourage the development and recruitment of qualified public health workers.

Maintaining a competent public health workforce requires a supply of qualified public health workers sufficient to meet public health needs. As public health workers retire or seek other employment opportunities, newly trained public health workers must enter the field. Trained and competent workers are needed in such diverse areas as epidemiology, health education, community health, public health laboratory science, public health nursing, environmental public health, and public health administration and management. Every health department has a responsibility to collaborate with others to encourage the development of a sufficient number of public health students and to encourage qualified individuals to enter the field of public health to meet the staffing needs of health departments and other public health organizations. Recruitment and hiring efforts should seek to develop a workforce with the necessary capabilities that reflects the characteristics and demographics of the populations served.

MEASURE 8.1.1 S:

Build relationships with educational programs that promote the development of future public health workers.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** contributions to the development of qualified public health workers, as part of an ongoing relationship with an educational program. Collaborative efforts promote public health as a career option and the health department as an employer of choice and open new pathways for recruitment. Collaboration with academic programs can create opportunities for internships, guest lectures, and other ways to expose students or new graduates to public health practice.

MEASURE 8.1.1 S: Required Documentation 1	Guidance	Number of Examples 1 example	Dated Within 5 years
1. Ongoing relationship with a school of public health or other academic program to promote public health careers or enhance training in public health.	Working with schools or programs of public health and other related academic and educational programs is a means to promote public health as an attractive career choice. Schools or programs could include, for example, public health nursing, public health laboratory services, public health informatics, health promotion, environmental public health, public policy, preventive medicine, or other related study areas at community colleges, Tribal colleges, or other colleges and universities. Promoting public health careers through an ongoing and established relationship could be demonstrated by, for example, recurring guest lectures, health department staff teaching public health courses, health department participation in annual career fairs, or establishing enhanced training opportunities (e.g., internships or practicums). Evidence of providing an agreement for nursing rotations that is only clinical would **not** be appropriate. However, rotations that included both non-clinical, population public health work, and clinical work could be provided. A practicum agreement for rotations focused on environmental health, surveillance, health promotion, or emergency preparedness would also be acceptable. The intent is to demonstrate an ongoing relationship rather than a one-time example—in other words, a one-time guest lecture would **not** meet the intent of the requirement. This ongoing relationship could be demonstrated by providing evidence of how the health department interacted with the school in the same manner multiple times (e.g., a practicum agreement between the school and the health department through which multiple students have participated) or by showing multiple different interactions between the health department and the school (e.g., showing participation in a career fair and as a guest lecturer). **Documentation Examples** Documentation could include, for example, practicum, placement, or internship agreements with colleges or universities with evidence that multiple students have participated; evidence of participating in a career fair or providing guest lectures over multiple semesters (or a combination of various activities); evidence of developing or maintaining an Academic Health Department (e.g., Academic Health Department agreement).		

MEASURE 8.1.1 T/L:

Collaborate to promote the development of future public health workers.

Purpose & Significance

The purpose of this measure is to assess the **Tribal or local health department's** collaborative activities to encourage public health as a career choice. Collaborative efforts promote public health as a career option and the health department as an employer of choice and open new pathways for recruitment. Collaboration with academic programs and other organizations can create opportunities for internships, guest lectures, and other ways to expose individuals to public health practice.

MEASURE 8.1.1 T/L: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Participation in a collaborative activity that promotes public health as a career choice.	Working with youth organizations, libraries, community groups, elementary or high schools, schools or programs of public health, or other related academic and educational programs is a means to promote public health as an attractive career choice. Schools or programs could include, for example, public health nursing, public health laboratory services, public health informatics, health promotion, environmental public health, public policy, preventive medicine or other related study areas at community colleges, Tribal colleges, or other colleges and universities. Collaborations can create paths for exposing individuals to public health practice. Promoting public health as a career choice could be demonstrated through, for example, an internship or practicum agreement for hands-on learning, guest lecture on public health as a profession for students of any age (e.g., at a school or to a youth organization), health department participation in a career fair, or development or maintenance of an Academic Health Department (e.g., Academic Health Department agreement). Evidence of providing a nursing rotation that is only clinical would **not** be appropriate. However, a rotation that included both non-clinical, population public health work and clinical work could be provided. Rotations focused on environmental health, surveillance, health promotion, or emergency preparedness would also be acceptable. **Documentation Examples** Documentation could be, for example, an internship or practicum agreement, participation in a career fair, or a guest lecture or presentation on public health as a profession (e.g., provided to a high school, vocational training school, community college, college of public health, public library, youth organization, AmeriCorps, or 4H club).		

MEASURE 8.1.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Recruit a qualified and diverse health department workforce.

Purpose & Significance

The purpose of this measure is to assess the health department's recruitment or hiring process to ensure a diverse staff that has the capabilities needed to serve the community. Health departments' success, as in all organizations, depends on the capabilities and performance of its staff. Recruitment and hiring strategies should focus on attracting and building a qualified public health workforce, which is necessary for a health department to function at a high level. A diverse workforce reflects the characteristics and demographics of the population using health department services and builds understanding of the perspectives and needs of the community.

MEASURE 8.1.2 A:

Required Documentation 1

1. Recruitment or hiring efforts aimed at securing a qualified and diverse workforce.

For health departments with fewer than 2 opportunities to recruit or hire in the last 5 years, the health department is required to provide a process or plan of how they would recruit or hire qualified and diverse new employees in the event of a future vacancy.

Guidance

Number of Examples
2 examples

Dated Within
5 years

The intent of this requirement is to demonstrate the department's efforts to recruit or hire a qualified and diverse workforce, not the success or failure to achieve the desired applicant pool or workforce. Health departments can provide examples related to recruitment, or retention, or both. Health departments can provide examples of successful or unsuccessful efforts to work with its human resources department to secure a qualified and diverse workforce.

Including an EEO statement in a job posting does **not, on its own,** meet the intent of this requirement.

Recruitment efforts could include the qualifications listed within a job description, the methods used for recruitment, or both. The qualifications could include competencies, knowledge (education and experience), skills, or abilities that correspond to the technical demands of the position (e.g., data collection or analysis) or that are more cross-cutting (e.g., strategic thinking or collaboration). The methods for recruitment can be tailored to encourage a diverse pool of applicants. For example, health departments could disseminate job openings by working with community partners or community members or by using targeted media outreach.

Hiring efforts could include, for example, maintaining a system to track recruitment or hiring processes which consider workforce diversity (including identifying when candidates drop out of the hiring process), examining and trying to reduce implicit bias within hiring processes, or acknowledging lived experience as relevant for positions that address the root causes of health inequities or social determinants of health.

When HR functions are outside the health department, the documentation could demonstrate the health department, for example, providing suggestions to HR on a recruitment or hiring policy, reviewing qualifications listed in a job description, providing suggestions on the dissemination of job openings, or working with HR to establish systems or processes that considers workforce diversity.

Tribal health departments may use Indian Preference hiring policies.

A workforce could be diverse as it relates to, for example, race/ethnicity, culture, language, age, gender, or specific geographic area of the health department's jurisdiction. Health departments could conduct outreach to recruit, for example, veterans, individuals with disabilities, or those with lived experiences, such as people in recovery (substance use program areas) or breastfeeding mothers (peer counselors, MCH). The health department may seek to recruit and hire a workforce that reflects the characteristics and demographics of the population using health department services.

Documentation Examples

Documentation could include, for example, job postings in media sources that reach specific populations, competency-based job descriptions in newsletters directed towards the specific population being sought, or participation in career fairs focused on a particular demographic with a posting that specifies the level of skills, training, experience, and education that the applicant needs to qualify for the position.

STANDARD 8.2

Build a competent public health workforce and leadership that practices cultural humility.

A health department workforce development plan ensures that staff development is addressed, coordinated, and appropriate for the health department's needs. Professional development opportunities to support individual and organizational growth, as well as a supportive work environment, can help public health employees thrive.

MEASURE 8.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.

Purpose & Significance

The purpose of this measure is to assess the health department's workforce development plan that assesses the workforce's ability to maintain core public health, equity-focused, and administrative capabilities and identifies strategies to improve the workforce. Health departments must have the capacity to perform core public health functions to meet the current and evolving needs of the community it serves. A competent workforce is equipped with skills and experience needed to perform their duties to effectively carry out the health department's mission and advance the health of the community. This includes ensuring the workforce is equipped to promote equity, diversity, and inclusion. Workforce development strategies are tailored to the needs of the community and designed to support the health department, as well as staff members' training and professional development needs.

MEASURE 8.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. A health department-specific workforce development plan that includes:	The workforce development plan articulates specific objectives and strategies the health department plans to undertake to achieve its desired future workforce. The workforce development plan is based on considerations of the health department's current gaps in capacity and capabilities, particularly within areas in which the field is advancing.		
a. A description of the current capacity of the health department both as a whole and within its sub-units.	**For required element a:** The health department could use various tools or assessments to understand the current collective capacity of the department—in other words, does the health department have the number of staff needed in appropriate roles to meet the needs of the population it serves. Methods could include, for example, calculating health department current and projected needed staffing capacity; or using tools or resources such as, the Uniform Chart of Accounts, PH WINS (Public Health Workforce Interests and Needs Survey), or Staffing Up: Determining Public Health Workforce Levels Needed to Serve the Nation. The workforce development plan could include benchmarking to other health departments that perform similar functions within similarly sized jurisdictions, but such comparisons are **not** required. Within the assessment, there will be at least some discussion of the capacity of different sub-units (e.g., divisions or program areas). However, it is **not** necessary that the capacity assessment be as in depth about each of those sub-units. It would be sufficient, for example, to identify which sub-units are experiencing the largest capacity gaps or to focus on one or two sub-units (e.g., to compare the health department's epidemiological capacity with current needs). The workforce development plan, or an appendix, will include a summary of the findings.		
b. An organization-wide assessment of current staff capabilities against an accepted set of core competencies.	**For required element b:** The intent of this required element is to understand whether staff have the skills needed to perform their job functions. A core competency assessment could include, for example, a nationally recognized model (e.g., the Core Competencies for Public Health Professionals from the Council on Linkages Between Academia and Public Health Practice or the skills outlined in the needs assessment of PH WINS), state-developed competencies, specialty-focused competencies (e.g., nursing, epidemiology, public health preparedness, informatics, or health equity competencies), or an internally developed set of competencies. Health departments could also use modified or condensed versions of existing competency sets or combine competency sets, to be better tailored to their organizations. A core competency assessment could be conducted on behalf of the health department by a consultant or another entity as long as the assessment provides results specific to the health department's staff. The workforce development plan, or an appendix, will include a summary of the findings from this assessment.		

MEASURE 8.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
c. Findings from an equity assessment that considers staff competence in the areas of cultural humility, diversity, or inclusion.	**For required element c:** The intent of this required element is that the health department consider the workforce's competence related to equity. While health departments are encouraged to assess cultural humility, diversity, and inclusion, demonstrating a minimum of one is required. Aspects of this competence could be assessed through, for example, the Cultural and Linguistic Competency Policy (CLCPA) self-assessment from the National Center for Cultural Competence, an assessment against the Culturally and Linguistically Appropriate Services (CLAS) standards, the Health Equity at Work: Skills Assessment of Public Health survey, a review against the Attributes of a Health Literate Organization, or another assessment tool. It could also reflect an emphasis on cultures in the health department's jurisdiction (e.g., cultural traditions of American Indians, or immigrant communities). The equity assessment could also be one component of a broader assessment (e.g., equity-related questions in PH WINS or the Core Competencies assessment). The workforce development plan, or an appendix, will include a summary of the findings from this assessment.		
d. Priority gaps identified with an explanation of the prioritization. At least one of the prioritized gaps must relate to the findings of the assessments in required element a, b, or c.	**For required element d:** The intent of this required element is that the health department prioritizes gaps in the existing capacity or capability of its workforce. The health department will provide an explanation for why those gaps were prioritized. While the prioritized gaps will be in the documentation, the explanation could be in the Documentation Form. At least one of the prioritized gaps will be based on the assessments described in required elements a, b, or c. Prioritization of the other gaps could also be from those assessments or could be, for example, capacity or capability needed to fulfill objectives in the strategic plan or priorities in the state/Tribal/community health improvement plan. Prioritized gaps could also reflect the evolving public health landscape, for example, informatics expertise, use of new or more advanced technologies, social determinants of health, social or environmental justice, communication science (e.g., use of web or social media platforms), innovation methods, emergency preparedness or response, public health sciences (e.g., epigenetics), or climate change.		
e. Plans to address at a minimum two of the gaps in required element d; for each gap, documentation must include: i. Measurable objectives. ii. Improvement strategies or activities with timeframes.	**For required element e:** Plans will relate to the gaps identified in required element d. Objectives will be written in measurable form with corresponding activities that have timeframes for completion. For example, the health department's improvement strategies or activities could address gaps in capacity related to staffing shortages through plans to hire (e.g., requesting funding to hire) nursing or epidemiology staff to respond to infectious disease outbreaks, cross-training staff so that individuals who originally worked in one program can serve in a different program, or by conducting a salary assessment to justify requests to be able to provide compensation that appropriately reflects skills in order to improve retention. Gaps in capabilities could be addressed, for example, by planning training for environmental health staff about new enforcement requirements.		

MEASURE 8.2.1 A:	Guidance	Number of Examples	Dated Within
Required Documentation 2		1 list	2 years
2. A list of learning or educational opportunities that relate to the gaps in capacity or capabilities identified within the workforce development plan (Required Documentation 1, required elements a or b) or the equity assessment (Required Documentation 1, required element c). At least one of the learning or educational opportunities will include training on equity, diversity, inclusion, or cultural humility.	The list of learning or educational opportunities could be part of the workforce development plan or a companion document. While the plans to address gaps in capacity or capabilities within the workforce development plan may include an objective(s) that training is needed (Required Documentation 1, required element e), the learning or educational opportunities list (Required Documentation 2) will specify the specific courses or training opportunities. The intent of this requirement is that the health department develop—or leverage existing—learning curricula that correspond to identified gaps in capacity or capability based on the assessment within the workforce development plan. Learning opportunities could help the health department to address capacity gaps by allowing existing staff to be cross trained to take on new roles. The list could consist of opportunities compiled and available through learning management systems, such as the Public Health Foundation's TRAIN Learning Network. The list could include, for example, learning and educational opportunities with a brief description of the content, learning objectives, availability or frequency of offerings, or format (e.g., in person or virtual). Topics for the staff training on equity, diversity, inclusion, or cultural humility could include, for example, examining biases and prejudices; developing cross-cultural skills; learning about specific populations' values, norms, traditions, and narrative; or learning, with people with lived experience, about how to develop programs and materials for individuals who have low literacy skills, speak a different language, or are blind or deaf. Trainings could include, for example, the Racial Equity Institute, Prevention Institute's Health Equity Training Series, the National Association of County and City Health Officials' Roots of Health Inequity, Robert Wood Johnson Foundation's Health Equity: Why it Matters, and How to Take Action, or trainings available through the Public Health Learning Network (PHLN), or Public Health Foundation's TRAIN Learning Network.		

MEASURE 8.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Provide professional and career development opportunities for all staff.

Purpose & Significance

The purpose of this measure is to assess the health department's comprehensive approach to providing opportunities for professional career development for all staff and the department's implementation of leadership/management development activities. All staff should have opportunities for professional development, which include opportunities to learn and to grow in their positions both to improve their own skills and also to address the changing needs of the health department. In addition to their specific public health activities, leaders and managers must oversee the health department, interact with stakeholders and constituencies, seek resources, interact with governance, and inspire employees and the community to engage in healthful activities. Leadership/management development activities can assist staff to employ state-of-the-art techniques to lead people and organizations.

MEASURE 8.2.2 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	2 years
1. Individualized professional development plans for non-managerial staff **and** progress toward completion. Each example must be for a different employee's professional development plan.	The intent of this requirement is **not** to show performance reviews; rather, the intent is to show that professional development activities are identified and tailored towards meeting professional development needs. Those needs could be based on the position or the health department's strategic workforce development needs (e.g., a professional development plan with learning or training opportunities for a staff member based on a promotion or new job duties or a professional development plan that includes an emphasis on equity consistent with the health department's identification of that as a department-wide priority). In cases where a professional development plan is part of an employee's performance review, the performance review section may be provided with personal information redacted. Professional development activities could include, for example, education assistance (e.g., time off for classes, tuition reimbursement, bringing classes to the health department), continuing education, training opportunities, mentoring, job shadowing, professional coaching, certification in public health, engagement in professional associations (e.g., serving on committees, reviewing conference abstracts), or opportunities to apply learned skills in their position. Topics could include, for example, conflict negotiation; customer service skills; community resilience; emergency response; presentation or public speaking skills; informatics or data visualization; equity, justice, diversity, and inclusion; or effective or persuasive communications. This could also include courses required for continuing education for Certified in Public Health, Certified Health Education Specialist, or other credentials. **Documentation Examples** Documentation could include, for example, an excerpt from an employee's annual goals or professional development plan **and** evidence of completion of at least some of the recommended training or learning opportunities. That evidence of completion could include, for example, a certificate, an attendance record for a class, a report written by the staff person documenting the activities and learnings, receipt or memo showing reimbursement for training or time off granted to attend courses, or support for membership in a professional association.		

MEASURE 8.2.2 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 2 years
2. Participation in leadership or management development learning opportunities.	The intent of this requirement is to show that there are specific learning opportunities to strengthen management or leadership skills. The recipient of those learning opportunities could be an existing leader or manager, could be staff who are not currently in a leadership role as part of a career ladder to advance, or could be part of succession planning. Topics of learning opportunities could include, for example, negotiation skills, strategic management, emotional intelligence, adaptive leadership, change management, intercultural or intergenerational management, collaborative intelligence, handling conflict, coaching and mentoring skills, communications skills for managers, leadership styles, effective networking, leading teams and collaborations, or diversity, equity, and inclusion. Trainings could be provided by entities such as National Public Health Leadership Institutes, Public Health Training Centers, the Environmental Public Health Leadership Institute, or academic institutions. Trainings could be provided by state or local entities, as well. The leadership training does **not** need to be public health focused. **Documentation Examples** Documentation could include transcripts, certificates, attendance records, or emails confirming participation in executive management seminars or programs, graduate programs in leadership or management, or related meetings and conferences.		

MEASURE 8.2.3 A:

Build a supportive work environment.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to create an organizational culture and work environment that is supportive of the staff and to evaluate staff satisfaction. The work environment impacts job satisfaction, employee retention, and employee creativity and productivity. The work environment should support and foster each employee's ability to contribute to the achievement of the department's mission, goals, and objectives.

MEASURE 8.2.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or set of policies	**Dated Within** 5 years
1. A comprehensive policy or set of policies that demonstrate a supportive work environment, which must address, at minimum, one provision of each of the following:	The intent of this requirement is to provide policies that build a supportive work environment for staff that goes above and beyond state or federal laws. Documentation of examples affecting just one employee (e.g., a recognition of just one worker) would **not** be appropriate.		
a. Employee wellness.	**For required element a:** A policy could include, for example, health screenings and risk assessments, flu shots, exercise programs, nutrition information, stress reduction methods, employee assistance programs, tobacco/other substance use cessation programs, healthy food or physical activity policies or programs, or other efforts to create a culture of health and wellness. The policy could also address measures taken to support employees during public health emergencies to address the additional stress that can result from response. Documentation could be part of another plan or procedure (e.g., continuity of operations or surge plan).		
b. Work-life balance.	**For required element b:** A work-life balance policy could include, for example, telecommuting, flexible schedules, allowing staff to bring children to work, or breastfeeding/lactation support. This policy could be part of a broader employee wellness policy, if that wellness policy contains provisions related to both work-life balance and other aspects of wellness.		
c. Employee recognition.	**For required element c:** An employee recognition policy could describe processes to recognize staff through, for example, a newsletter, employee of the month program, employee honor roll, recognition letter, or regularly organized recognition lunch.		
d. Inclusive culture.	**For required element d:** Fostering an inclusive workforce could focus on building an authentic workplace, which creates a welcoming and open-minded environment that nurtures individual expression of thoughts or feelings rather than conformity. A policy could include, for example, listing pronouns in email signatures, requiring unconscious bias training for all employees, acknowledging holidays of all cultures and providing employees the flexibility to use paid time off for those days, or establishing an inclusion council or employee resource group.		

MEASURE 8.2.3 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
2. Assessment of staff satisfaction **and** actions taken, including:	The intent of this requirement is to collect feedback across the department and implement actions, which could be department-wide or related to sub-units. Examples do **not** need to be extensive or costly. The assessment could be coupled with another assessment, such as a QI or workforce equity assessment. In a centralized state, the state health department's assessment and actions taken could include staff serving local jurisdictions.		
a. Systematically collecting feedback from staff.	**For required element a:** Documentation of collecting feedback from staff could include, for example, spreadsheets of assessment data, or instruments such as forms, web surveys, or other methods. The assessment could be created and disseminated by the health department or by an outside organization (for example, the PH WINS survey). An employee suggestion box would **not** meet the intent of conducting an assessment. Evidence will demonstrate feedback on staff satisfaction was collected; individual responses are **not** required.		
b. Drawing conclusions and making recommendations based on the feedback.	**For required element b:** That feedback will inform conclusions, which could include identification of, for example, themes about what the health department is doing well or implications for the health department (e.g., addressing a high-priority concern may be key to reducing burnout), as well as recommendations for acting on those findings. Documentation could include, for example, meeting minutes or a summary report. The health department may want to disaggregate this feedback based on employee information (e.g., demographics, longevity of employment with the health department, or supervisory vs. non-supervisory role) in order to understand how satisfaction may vary based on employee characteristics and tailor strategies accordingly.		
c. Taking action based on the conclusions drawn from the staff satisfaction assessment.	**For required element c:** Documentation of taking action could include, for example, meeting minutes of actions taken, completed QI project summaries to address opportunities for improvement, revised policies or procedures, evidence of staff events, evidence of new or revised communication methods from leadership, or evidence of other activities in response to the conclusions drawn based on the staff satisfaction assessment. The actions could focus on feedback collected from across the department or its sub-units or one particular topic or process, rather than overall satisfaction. If no opportunities are identified in required element b, the health department could demonstrate expanding on strengths across the department (e.g., if the health department received positive feedback about some of the professional development or training opportunities that are available, it could seek to expand the number of employees who participate in those opportunities).		

MEASURE 8.2.4 S:

Advance Tribal and local health department workforce development efforts.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** efforts to strengthen the collective capacity and capabilities of the public health system by supporting the workforce of Tribal and local health departments. State health departments play an important role in strengthening public health infrastructure by supporting Tribal and local health departments to recruit, retain, and develop a competent public health workforce. The state health department may have knowledge and experience to share about workforce capacity, workforce training, and continuing education to address organizational gaps in the public health workforce. The state health department could also support learning among Tribal and local health departments related to workforce development.

MEASURE 8.2.4 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
1. Information sought or reviewed to understand the needs of multiple Tribal **and** local health departments regarding strengthening the public health workforce. The example must include seeking or reviewing information about at least one Tribal health department **and** one local health department. If there is not a Tribal health department in the state, this must be indicated in the Documentation Form.	The intent of this requirement is for the state health department to develop an understanding about what might support Tribal and local health departments in strengthening their workforce. An example about just one health department would **not** meet the intent of this requirement. If, for example, the state health department is gathering information through phone calls with individual health departments, the documentation could show notes from two phone calls with different health departments. Seeking information could include, for example, efforts by the state to ask local and Tribal health departments about technical assistance needs or suggestions through a survey, phone call, or meeting. If the state health department can document that it asked for feedback, it is **not** necessary to demonstrate that feedback was received. Other examples of gathering or seeking information could include, for example, reviewing requests or questions that the health department received from local and Tribal health departments, using existing sources of information on common barriers among Tribal and local health departments (e.g., reviewing local or Tribal workforce needs assessments or workforce development plans), or engaging local and Tribal health departments in the development of a statewide workforce development plan or initiative. The state health department **cannot** use examples of seeking information about program divisions within the state health department's central office and their needs. In a centralized state, the examples could be information from or about the staff serving local jurisdictions and Tribal health departments. **Documentation Examples** Documentation of seeking information could be, for example, emails, phone call minutes, newsletters, memos, meeting minutes, notes from conversations (e.g., Council or Nations leadership meetings), or results of a survey with questions designed to understand the needs among Tribal and local health departments. If the health department uses an existing source of information (e.g., local or Tribal workforce needs assessments), the documentation could be supplemented with an explanation in the Documentation Form about how this information was reviewed.		

MEASURE 8.2.4 S:	Guidance	Number of Examples	Dated Within
Required Documentation 2		2 examples	5 years
2. Support provided to Tribal or local health departments to be responsive to their needs regarding strengthening the workforce. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state, this must be indicated in the Documentation Form and two examples with local health departments must be provided.	The state health department will document that it has provided training or other support in order to bolster the workforce of Tribal and local health departments. A broad workforce development effort not focused on meeting the needs of one or more Tribal or local health departments—for example, a collaboration with a school of public health to promote public health careers, in general—would not meet the intent of the requirement, unless the example included coordination with one or more Tribal or local health department(s) or efforts to facilitate placements with Tribal or local health department(s). ▪ Support provided to Tribal or local health departments could include, for example: ▪ Funding workforce capacity building, learning activities, professional development activities, or other resources (e.g., access to learning management systems). ▪ Developing a leadership program open to health departments across the state. ▪ Working collaboratively with schools or programs of public health or other academic institutions to develop resources for use by Tribal or local health departments related to recruitment, retention, or succession planning. ▪ Conducting workforce assessments and using results for collective problem-solving to address gaps in workforce capacity or capabilities among Tribal or local health departments. ▪ Convening a learning community to enable health departments to learn from each other about workforce development strategies. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be support to staff serving Tribal health departments and local jurisdictions. Examples could be related to the activities described in Required Documentation 1, but do **not** need to be. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and that recognition of Tribal sovereignty was considered in communication or decision making. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is **not** required. The Documentation Form could describe, for example, a suggestion made by the Tribal or local health department on a phone call, in a meeting, or through an email. **Documentation Examples** Documentation could be, for example, newsletters, memos, meeting minutes, presentations at conferences or webinars, phone call minutes, or funding or other agreements.		

DOMAIN 9

Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.

Domain 9 focuses on the use and integration of performance management and quality improvement practices for the continuous improvement of the health department's processes, programs, and interventions. The domain also emphasizes the importance of research, evaluation, and innovation as tools to support continuous improvement.

Performance management identifies actual results against planned or intended results. Performance management systems ensure that progress is being made toward department goals by systematically collecting and monitoring data to track results and identify opportunities for improvement. Quality improvement is an element of performance management that uses processes to achieve specific targets for effectiveness and efficiency.

DOMAIN 9 INCLUDES **TWO** STANDARDS		
Standard 9.1:	Build and foster a culture of quality.	
Standard 9.2:	Use and contribute to developing research, evidence, practice-based insights, and other forms of information for decision making.	
FOUNDATIONAL CAPABILITY MEASURES:		
Accountability & Performance Management	**9.1.1 A:**	Establish a performance management system.
	9.1.5 A:	Implement quality improvement projects.
	9.2.1 A:	Identify and use applicable research and practice-based information for program development and implementation.

STANDARD 9.1

Build and foster a culture of quality.

The performance management system serves as the framework to set goals, measure progress, report on progress, and make improvements. The process should encourage a culture of organizational learning within the health department. Monitoring data through the performance management system is one mechanism for identifying opportunities for improvement, growth, and learning within the health department.

An important component of an effective performance management system is the implementation of quality improvement projects. Infusing the ongoing use of performance management and quality improvement throughout the health department fosters continuous improvement among staff.

MEASURE 9.1.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Establish a performance management system.

Purpose & Significance

The purpose of this measure is to assess the department-wide performance management system. A performance management system encompasses establishing and evaluating the achievement of goals, objectives, and improvements or actions across programs, policies, and processes. The design of the performance management system should consider community health needs and priorities, including health inequities or disparities. Tools like logic models can help health departments determine which objectives to track in order to understand how the work of the health department, along with the broader public health system, contributes to improving health outcomes. An adopted performance management system fosters transparency by communicating across the department how the department will (1) ensure that goals are being met consistently in an effective and efficient manner and (2) identify opportunities for improvement.

MEASURE 9.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 performance management system	**Dated Within** 5 years
1. A department-wide performance management system, which includes:	The intent of this requirement is to demonstrate how the health department uses one department-wide system that tracks data on specific objectives to understand progress towards performance goals. Showing the goals and objectives of one grant program, for example, would **not** meet the intent of the requirement. To document required elements a, b, and c, a combination of documents could be used, such as screenshots, policy(ies), and descriptions. Performance could be managed in, for example, a software program purchased or developed by the health department, an Excel workbook, or other mechanism. The performance management system may be part of a larger performance management system (e.g., a Tribal health department's performance management system may, for example, be part of an integrated system with health care; or a local health department in a centralized state may be part of the state health department's system). However, if that is the case, at least some of the goals and objectives in required element a will be relevant to the health department or population health of the jurisdiction served by the health department. The performance management system may contain primary data collected by the health department or secondary data collected by others. The data can be qualitative or quantitative. Different types of data—customer feedback, programmatic, and administrative—are used to measure performance toward different objectives. The health department could include data from, for example: ▪ State-based information systems to determine if it is meeting performance goals established through state program requirements. ▪ Surveillance systems to determine if it is meeting performance goals associated with the timeliness of disease investigation or reporting. ▪ Internal data systems for collecting progress updates from staff responsible for strategic plan objectives.		
a. Performance management goals **and** the associated objectives with time-framed and measurable targets.	**For required element a:** Goals are established by the health department and are intended to serve as the anticipated result or outcome the health department desires to achieve. Goals will have associated objectives (could be termed as measures or indicators). Objectives will be written in measurable and time-bound form, and can be used to assess the extent to which programs, policies, and processes are achieving intended results. Objectives could be written, for example, in SMART or SMARTIE (Specific, Measurable, Attainable, Relevant, and Time-bound and/or through an Inclusive and Equitable lens) form. The health department could, for example, set their performance objectives based on a combination of the following: ▪ National, state, or other scientific guidelines (e.g., Healthy People 2030, state program requirements, or accreditation standards and measures).		

MEASURE 9.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 performance management system	Dated Within 5 years
	▪ Funders' performance or reporting requirements (e.g., outlined in grant requirements). ▪ Benchmarks derived from peer organizations (e.g., neighboring health departments or health departments of similar size/characteristics). ▪ Expectations of the public or leadership (e.g., public health performance objectives set by the governing entity). ▪ Organizational or programmatic plans or workplans (e.g., targets established through strategic plan, health improvement plan, or workforce development plan; or targets established through program-level workplans). Documentation may demonstrate a sub-set of the goals and objectives in the performance management system through screenshot(s) or other documentation. The documentation does not need to show every goal and objective, but will reflect the breadth of the goals and objectives included in the performance management system.		
b. A description of how the performance management system operates, including the process for how staff will: i. Enter data in the performance management system. ii. Monitor data on performance. iii. Communicate results on a regular reporting cycle. iv. Use data to guide decision-making. v. Use data to facilitate continuous quality improvement.	**For required element b:** The description of the performance management system could be a description, policy, or plan (separate plan or integrated with the QI plan or other health department plan). It will describe how the following processes generally occur, but does not need to go into detail about each individual objective. For example, in describing how staff enter data into the system, it would be sufficient to list the methods used to collate data into the system without indicating which method applies to each specific objective. The description will include the process for how staff do each of the following: i. Enter data in the system. Performance measurement data can be derived from multiple data systems or data collection processes. Some could be directly transferred into the performance management system from another data source (e.g., if there is a connection to HR, financing, or surveillance data systems) or could be entered by staff. ii. Monitor data on performance. This could include, for example, how data are tracked to determine whether progress has been made towards meeting the objectives. iii. Communicate results on a regular reporting cycle. This could include, for example, regularly summarizing data on performance objectives (e.g., monthly, quarterly, or annually) and sharing this information with stakeholders (e.g., the health department director, members of the governing entity, staff, or members of the public). Documentation of progress reporting could include, for example, a dashboard accessible to others, quarterly reports sent to stakeholders, newsletters, meeting agendas and minutes, or presentations. iv. Use data to guide decision making. The health department could use performance management data analyses to, for example, guide decisions on where resources should be allocated or adjusted to improve efficiencies or effectiveness, or identify an unmet community need. v. Use data to facilitate continuous quality improvement. Monitoring progress in performance management data could lead to the identification of a quality improvement project, for example.		

MEASURE 9.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 performance management system	**Dated Within** 5 years
c. Linkages between the performance management system and strategic plan. (If the linkages are not evident in the example, they could be indicated in the Documentation Form.)	**For required element c:** Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities. The performance management system does **not** need to link to all elements of the strategic plan, but it will show where linkages are appropriate for effective planning and implementation. A statement simply stating the performance management system is aligned to the strategic plan would **not** suffice. The Documentation Form may be used to clarify or describe linkages, for example, by indicating which specific priorities in the strategic plan are being tracked through the performance management system.		

MEASURE 9.1.2 A:

Implement the performance management system.

Purpose & Significance

The purpose of this measure is to assess the health department's use of performance management practices in assessing performance and managing opportunities for improvement. A performance management system ensures that progress is being made toward department goals and allows the department to identify areas for quality improvement. Including customer feedback in the performance management system can amplify community voice and needs, especially among populations facing health disparities or inequities.

MEASURE 9.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Implementation of the performance management system, which must include each of the following for two performance goals:	The intent of this requirement is to demonstrate use of the performance management system. Goals could focus on, for example, regulatory or enforcement actions (e.g., tracking whether restaurant inspections are performed according to mandated inspection schedules), health education or promotion activities (e.g., reach of health education messages in the community), contract management (e.g., tracking whether contracts are approved within an established timeframe), human resources functions (e.g., improving recruitment processes), staff professional development (e.g., effectiveness of the professional development process or whether staff are achieving professional development goals), workplace development (e.g., effectiveness of employee wellness program), or financial management system (e.g., process for tracking spend down).		
a. Objective(s) with identified timeframe(s) for measurement.	**For required element a:** Timeframes for measuring objectives (e.g., monthly or quarterly) establish a target date by which progress toward accomplishing goals will be assessed in order to foster accountability.		
b. The data for each objective. At least one of the objectives must use customer feedback data.	**For required element b:** Data could be collected from secondary sources to which the health department has access or primary data collected by the health department. Examples of data could include, for example, 7 days to execute a contract or 57% of adults are vaccinated. Customer feedback data could be collected from surveys, focus groups, interviews, or other methods to gather data. These data may be the same as or different from the examples required within 9.1.3 A. In the context of this requirement, "customer" refers to the group impacted by the performance management goal. In this sense, customers may refer to partners or key stakeholders or, if it's an administrative goal, the customers may be internal to the health department.		
c. Tracking of progress toward achieving objectives.	**For required element c:** Tracking progress toward achieving objectives could include, for example, tracking or monitoring logs, performance management reports, or dashboards.		
d. Next steps for the identified goal, based on tracking progress.	**For required element d:** Next steps for the identified goals could include, for example, initiating a quality improvement project based on performance results or adjusting targets based on performance results.		

MEASURE 9.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
If the performance management system is part of a larger performance management system, the examples of implementation must be relevant to the health department or population health of the jurisdiction served by the health department.	**Documentation Examples** Documentation could include, for example, dashboards with notes indicating opportunities for improvement and next steps; performance management reports; monitoring logs or other tracking forms demonstrating progress in achieving measures with notes indicating opportunities for improvement and next steps; or meeting minutes from the health department team responsible for monitoring the performance management system.		

MEASURE 9.1.3 A:

Implement a systematic process for assessing customer satisfaction with health department services.

Purpose & Significance

The purpose of this measure is to assess the health department's process for systematically collecting and using customer feedback. Collection of customer feedback helps the health department to understand performance in the eyes of those it serves in order to be responsive to their needs. Customer satisfaction processes involve standardized data collection and use of the data to inform future action. Taking actions based on customer feedback demonstrates a commitment to accountability and fosters trust among community members.

MEASURE 9.1.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Feedback from **external customers** assessing customer satisfaction with health department services, which includes each of the following:	The intent of this requirement is to collect feedback from individuals outside of the organization about their interactions with the health department. Employee satisfaction surveys or surveys of community members about health priorities would **not** meet the intent of this requirement. Examples of processes that could be used to collect customer/stakeholder satisfaction could include, for example, forms, surveys, focus groups, or other methods. Customer groups could include, for example, vital statistics customers, food establishment operators, contractors, elected officials, partner organizations or agencies. The health department could also collect satisfaction information from WIC clients or clinic patients about the process of seeking services at the health department. A survey focused only on the clinical (medical) care an individual received would be outside PHAB's scope of authority.		
a. Data collection efforts that facilitate feedback collection from individuals of varying languages or ability, or who are otherwise disproportionately affected by health issues, higher health risks or poorer health outcomes.	**For required element a:** Special efforts in the design of data collection could include, for example, alleviating language barriers through the use of interpreters, data collection instruments available in other languages, or considering individuals with disabilities. Efforts to facilitate data collection could also include, for example, addressing trust through the use of lay advocates or community representatives to foster open dialogue; or convening focus groups or town halls with efforts to alleviate barriers (e.g., transportation). Evidence will demonstrate feedback was collected (e.g., through a summary of the data collection method in the report or by providing the data collection instruments and an explanation of how they were used); individual responses are **not** required. The Documentation Form could supplement documentation to explain how the effort facilitated data collection.		
b. Summary of findings about external customer feedback. Examples must be from two different external customer groups.	**For required element b:** The findings could include, for example, identification of themes or services the health department is doing well or opportunities for improvement. Documentation could include, for example, a report or presentation.		

MEASURE 9.1.3 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
2. Actions taken based on the findings from customer feedback from Required Documentation 1.	Examples of action taken based on customer feedback could include, for example, a quality improvement project, follow-up with staff or program areas identified in the feedback as having an opportunity for improvement, or a change in policy in response to findings from the examples in Required Documentation 1. Both actions could be based on the same collection of customer feedback from Required Documentation 1 or each action could be from a different data collection effort. In cases where feedback is positive and areas of improvement were not identified, the health department may show what actions were taken to continue the positive customer experience (e.g., applying similar approaches to other programs, or making a purposeful effort to continue or expand on successful approaches). **Documentation Examples** Documentation could include, for example, a report, meeting minutes, or other document that describes the action taken in response to the customer feedback findings.		

MEASURE 9.1.4 A:

Establish a process that guides health department quality improvement efforts across the department.

Purpose & Significance

The purpose of this measure is to assess the plan to support quality improvement throughout the department. To make and sustain quality improvement gains, a sound quality improvement process and infrastructure for implementing that process is needed. A quality improvement plan serves as a roadmap to establish shared goals across the health department to foster a culture of quality.

MEASURE 9.1.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. A quality improvement (QI) plan that addresses each of the following:			
a. List and description of key quality terms.	**For required element a:** Inclusion of key QI-related terms is intended to create a common vocabulary and clear, consistent message regarding QI among staff, leaders, and other stakeholders.		
b. Key elements of the QI structure, which must minimally include a description of roles and responsibilities of those responsible for the QI plan's implementation.	**For required element b:** In addition to roles and responsibilities of those responsible for the QI plan's implementation, the description could include, for example, organization structure for the QI process; membership and rotation of QI council/team members; descriptions of staffing or administrative support for the process; or descriptions of specific budget or resource allocation for the department's QI process.		
c. Description of QI learning opportunities offered to all levels of department staff.	**For required element c:** Delivery methods for QI learning opportunities could include, for example, new employee orientation presentations, introductory online courses for all staff, more advanced trainings for lead QI staff, hands-on workshops, or participation in learning communities. QI learning opportunities could be integrated in the workforce development plan training list or schedule, which may be provided as a companion document.		
d. Description of the process for identifying, prioritizing, **and** initiating QI projects.	**For required element d:** The health department's QI plan will include the steps for: identifying or collecting ideas for QI projects (e.g., from the performance management system, customer feedback, or staff suggestions); prioritizing ideas for QI projects (e.g., using tools like prioritization matrices, project nomination ranking or rating worksheets, nominal group or multi-voting techniques, strategy grids, or The Hanlon Method); and initiating a QI project for a prioritized idea (e.g., establishing a QI team and developing a charter). These steps may be contained within the plan or an appendix to the plan. Health departments could consider incorporating an equity lens to identifying and prioritizing projects. When identifying projects, the health department might, for example, consider the impact of projects on populations potentially affected and might gather input from those who would be affected to assess whether the project would be responsive to their needs. The health department might also consider how to ensure potential QI projects are inclusive and open to the diverse perspectives of staff, partners, or community members. Prioritization processes could also include equity-based values or factors in weighting criteria of a prioritization matrix or other consideration about which projects would have the greatest impact on equity. Quality is defined by the communities served: there is no quality without equity.		

MEASURE 9.1.4 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
e. Goals and objectives with time-framed targets, related to the department's QI plan implementation.	**For required element e:** The intent of this required element is for the health department to establish goals and objectives with time-framed targets pertaining to implementation of the QI plan itself. Goals and objectives related to specific QI projects or listing of QI projects would **not** meet the intent of this requirement. Goals and objectives could relate to, for example, QI training or learning opportunities offered for staff; the number or type of QI projects completed; the proportion of staff engaged in QI plan activities; communication of QI achievements or project outcomes to a variety of audiences; engagement of diverse teams in QI projects; or consideration of equity impact in selecting QI projects.		
f. Description of how implementation of the QI plan is monitored.	**For required element f:** The intent of this required element is to describe how the health department measures progress toward implementing the QI plan goals and objectives, as identified in required element e. Implementation of the QI plan could be monitored, for example, through the health department's performance management system, or by the QI Council/Team/Committee during their meetings.		
g. Communication strategies used to share with stakeholders about QI activities conducted by the health department.	**For required element g:** The QI plan will include a description of methods the health department may use to communicate its QI-related efforts to stakeholders. Stakeholders could be internal or external to the health department. Communications methods could include, for example, presentations with staff, members of the governing entity, or other health departments; QI newsletters; public display of QI storyboards; staff meeting updates or presentations; or other communications.		

MEASURE 9.1.5 A:

FOUNDATIONAL CAPABILITY MEASURE

Implement quality improvement projects.

Purpose & Significance

The purpose of this measure is to assess the health department's use of quality improvement to improve processes, programs, and interventions. Quality improvement projects that use recognized methods and tools to understand the current process and root causes, identify possible solutions, implement solutions, and use data to track the results can increase the effectiveness and efficiency of existing processes.

MEASURE 9.1.5 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Implementation of quality improvement (QI) projects that demonstrate the following:	To show implementation, the QI projects will have gone through at least one full project cycle—in other words, the health department will have reviewed its current process, tested out at least one solution, collected data on that solution, and identified next steps. Projects that have not yet completed one full cycle at the time of documentation submission would **not** meet the intent of this requirement. Examples will focus on improvement of existing processes by using a QI method and tools to understand the current process and root causes, identify and select solutions, and monitor progress towards measurable objectives. Demonstrating use of one QI tool for one part of the cycle (e.g., brainstorming possible solutions alone) would **not** be sufficient to meet the intent of this requirement. QI projects could focus on improving existing processes related to, for example, timesheet approval; inspection times for food, pool, or other establishments; accuracy or completeness of inspection reports; recruitment to increase the diversity of the hiring pool; new employee onboarding processes; the contracts management process; engaging partners or community members in the state/Tribal/community health assessment process; reduction of youth vaping rates; intake processes for community members using health department services; or community participation in a walking challenge intended to promote physical activity. Projects could also focus on exploring root causes or barriers to streamline or improve existing processes that could impact equity. This could include QI projects aimed to change existing processes in order to, for example, increase use of farmers markets in identified food desert areas; improve access to transportation systems; or streamline existing coordination of care processes using Community Health Workers or Community Health Representatives.		
a. How the opportunity for improvement was identified.	**For required element a:** Opportunities for improvement could be identified through use of data from, for example, the department's performance management system, other program or administrative data, audit findings, staff observation, or staff or customer feedback.		
b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement.	**For required element b:** Those engaged in the project will establish time-framed objectives to measure progress on what they are trying to accomplish. These statements are sometimes referred to as AIM Statements. Objectives could include, for example, within six months, reducing the number of days it takes to inspect and approve a new private septic system from five business days to three business days; or increasing from 40% to 60% the reach of a health education campaign about the benefits of the HPV vaccine among adolescents over the course of two months.		
c. Use of a QI method.	**For required element c:** Quality improvement methods could include use of, for example, Plan Do Study/Check Act (PDSA/PDCA); Six Sigma's Define, Measure, Analyze, Improve, Control (DMAIC); or Kaizen, lean, rapid cycle improvement, or other recognized QI methods.		

MEASURE 9.1.5 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
d. Use of QI tools to better understand or make decisions about: i. The current process. ii. Root cause(s). iii. Possible solutions. iv. Prioritization/ selection of solutions for implementation.	**For required element d:** QI tools appropriate for a given improvement model will vary based on the method selected and the type or problem identified. To examine the current process (i), the health department will document how the current process works and identify potential issues or opportunities for improvement. QI tools could include, for example, flowcharting or process mapping to document the way in which the process under study is currently operating. Examination of root causes (ii) and factors contributing to the issue under review provides further insight on opportunities for improvement. QI tools could include, for example, affinity diagrams, brainstorming, flowcharting, fishbone diagrams, 5 whys, check sheets, control charts, force field analyses, Gantt charts, interrelationship diagrams, logic models, pareto charts, and swim lane maps. Through the QI project, the health department may identify many possible solutions (iii) to test through the improvement effort. QI tools could include, for example, brainstorming and Strengths Weaknesses, Opportunities and Threats (SWOT) or Strengths, Opportunities, Aspirations, and Results (SOAR) Analysis. Once possible solutions are identified, the health department will use a process to prioritize which solution best addresses the issue (iv), for example, using a prioritization matrix. Elements that could be considered in prioritizing among potential solutions could include, for example, level of effort, expected impact, potential for unintended consequences, or the potential impact on equity.		
e. A description of the outcomes of the QI project, including progress toward the measurable objective(s) established in required element b. The description must include data used to determine whether the project's objective(s) was met and identify next steps resulting from the project.	**For required element e:** The example will show the solution was tested by the department and the results were assessed to determine if it results in the expected improvement. Based on the data about whether the test met the objective, the health department will determine next steps. The health department could, for example, plan to institutionalize the improvement as a new established process, or could determine they need to go back to an earlier step in their QI process and initiate another improvement cycle to test another possible solution. The health department could also consider any unintended consequences of the tested solution to ensure, for example, that increases in efficiency did not lead to decreases in effectiveness and that benefits of the QI project are equitably distributed. **<u>Documentation Examples</u>** Documentation could include, for example, storyboards for completed QI projects, QI project reports, or presentations of QI projects to health department staff, leaders, or other stakeholders.		

MEASURE 9.1.6 A:

Promote a culture of quality by engaging staff at all organizational levels in performance management and quality improvement.

Purpose & Significance

The purpose of this measure is to assess engagement of leadership and staff in developing, using, assessing, and updating performance management and quality improvement systems. A culture of quality is nurtured when health department leadership and staff at all levels are engaged in a deliberate approach to continually assess and improve performance. Engagement across the health department fosters awareness and alignment of the health department's units towards improving processes.

MEASURE 9.1.6 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Findings from a performance management or quality improvement (QI) self-assessment.	The health department could develop its own performance management or QI assessment or use existing models, for example, the Public Health Foundation's Public Health Performance Management Self-Assessment Tool, self-assessment tools available through the Baldrige Performance Excellence Program, or NACCHO's Roadmap to a Culture of Quality. **Documentation Examples** Documentation could include, for example, results summarizing a performance management or QI self-assessment, meeting minutes showing discussion of the results of a self-assessment, presentation, or report.		

MEASURE 9.1.6 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 or 2 committees, as needed	**Dated Within** 5 years
2. A functioning committee, team, or council responsible for:	The health department could have one team/committee/council focused on both performance management and QI or could have separate teams for each. These functions could also be the responsibility of another standing department committee, such as the management team or other internal team, committee, or council.		
a. Implementing the department's performance management system.	**For required element a:** The team implementing the department's performance management system could be involved with, for example, monitoring of goals and objectives, overseeing data collection, or using data to inform opportunities for improvement, decision-making, or next steps.		
b. Facilitating continuous QI.	**For required element b:** The team facilitating continuous QI could be involved with, for example, overseeing QI projects, providing opportunities for additional staff engagement in QI activities, developing QI training for staff, or developing methods to share QI news, resources, or results. **Documentation Examples** Documentation could include, for example, a team charter, meeting minutes, an excerpt of the QI plan, or performance management reports produced by the team/committee/council. The documentation could be supplemented with an explanation in the Documentation Form if the function of the team(s) is not evident in the documentation.		

MEASURE 9.1.6 A:	Guidance	Number of Examples	Dated Within
Required Documentation 3		2 examples	3 years
3. Staff at all levels, including leadership/management staff, engaged in developing or implementing the health department's performance management system or QI. The examples must include staff who are **not** in the committee/team/council described in Required Documentation 2.	The intent of this requirement is that both leadership/management **and** non-managerial/frontline staff are engaged in the health department's work related to the performance management system or QI. Intentional engagement of staff at all levels in decisions about the functionality and components of the performance management and QI systems fosters transparency and shared ownership among all staff. This could include, for example, engaging staff in developing and updating the list of performance goals and objectives. Similarly, involving staff in the development of the QI plan or in QI projects may help staff identify additional opportunities for improvement and may increase staff support for continuous QI. The intent is that the health department engage staff beyond those who are already part of the committee/team/council (unless all health department staff are included in that council) in order to infuse QI and performance management throughout the organization. Health departments can decide who to include from leadership. For Tribal Health Departments this could include, for example, the Health Department Director; a Tribal Council; a Tribal Health Advisory Board; an internal division or other administrative unit within a health department or Tribe; a Tribal Health Commission or Committee; a Tribal Health Board; or a Tribal Advisory Board of Commissioners.		

MEASURE 9.1.6 A:	Guidance	Number of Examples	Dated Within
Required Documentation 4		2 examples	5 years
4. Staff professional development completed in the area of performance management or QI.	The intent of this requirement is to provide evidence that learning opportunities have been delivered to staff on performance management or QI. This could include, for example, the learning opportunities referenced in 9.1.4 or other opportunities related to performance management or QI. It could also include, for example, evidence of the health department's work with consultants or technical assistance providers to develop staff skills in these areas. Documentation will show **both** the content of the learning opportunity (e.g., training curricula and objectives, presentation, webinars, training materials, a description of the consultant's engagement or a learning community) and evidence staff participated (e.g., attendance roster or post-training email). The documentation could be supplemented with a description in the Documentation Form of who attended the training.		

MEASURE 9.1.7 S:

Advance Tribal and local health department performance management systems or quality improvement.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** capacity to provide orientation, training, technical assistance, or other forms of support related to performance management or quality improvement to Tribal and local health departments. State health departments have an opportunity to share their expertise and best practice experiences with Tribal and local partners and create conditions in which the state's population benefits from locally improved processes, programs, and interventions. States can also learn from what works on the Tribal and local levels and support bringing those successful practices to scale throughout the state.

MEASURE 9.1.7 S:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 example	5 years
1. Information sought or reviewed to understand the needs of multiple Tribal or local health departments regarding performance management systems or quality improvement (QI). The example must include seeking or reviewing information about at least one Tribal health department and one local health department. If there is not a Tribal health department in the state this must be indicated in the Documentation Form.	The intent of this measure is for the state health department to develop an understanding of what might support Tribal and local health departments in strengthening their work related to performance management or QI. An example about just one health department would not meet the intent of this requirement. If, for example, the state health department is gathering information through phone calls with individual health departments, the documentation could show notes from two phone calls with different health departments. Seeking information could include, for example, efforts by the state to ask local and Tribal health departments about technical assistance needs or suggestions through a survey, phone call, or meeting. If the state health department can document that it asked for feedback, it is **not** necessary to demonstrate that feedback was received. Other examples of gathering or seeking information could include reviewing existing requests or questions that the state health department received from local or Tribal health departments, using existing sources of information on common barriers faced by Tribal and local health departments (e.g., reviewing local or Tribal QI culture assessments), or engaging local and Tribal health departments in the development of a statewide performance management system in which Tribal or local health departments will participate. The state health department **cannot** use examples of seeking information about program divisions within the state health department's central office and their needs. In a centralized state, the examples could be information from or about the staff serving local jurisdictions and to Tribal health departments. **Documentation Examples** Documentation of seeking information could be, for example, emails, phone call minutes, newsletters, memos, meeting minutes, notes from conversations (e.g., Council or Nations leadership meetings), or results of a survey with questions designed to understand the needs among Tribal and local health departments. If the health department uses an existing source of information, the documentation could be supplemented with an explanation in the Documentation Form about how this information was reviewed.		

MEASURE 9.1.7 S:	Guidance	Number of Examples	Dated Within
Required Documentation 2		2 examples	5 years
2. Support provided to Tribal and local health departments to be responsive to their needs regarding performance management or quality improvement (QI). One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state this must be indicated in the Documentation Form and two examples with local health departments must be provided.	The state health department will document that it has provided training or other support in performance management or QI practices, methods, or tools to Tribal and local health departments. Support could be provided by coordinating performance management system or QI trainings or webinars; creating communities of practice for sharing among practitioners; or providing resources, such as access to performance management system technology to support Tribal and local advances in performance management or QI. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be support to staff serving local jurisdictions or to Tribal health departments. Examples could be related to the activities described in Required Documentation 1, but do **not** need to be. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and that recognition of Tribal sovereignty was considered in communication or decision making. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is **not** required. The Documentation Form could describe, for example, a suggestion made by the Tribal or local health department on a phone call, in a meeting, or through an email. **Documentation Examples** Documentation could include, for example, trainings, presentations, or minutes from community of practice meetings with a description of participants; or documentation (e.g., newsletters, briefing papers, e-newsletters, email notification) of tools, performance management systems, or other resources provided to local and Tribal health departments.		

STANDARD 9.2

Use and contribute to developing research, evidence, practice–based insights, and other forms of information for decision making.

For the health department to most effectively and efficiently improve the health of the population, it is important to consider available research, evidence, and practice-based insights in the development of processes, programs, or interventions. Health departments also contribute towards building our understanding of public health by engaging in innovation and helping develop practice-based information.

MEASURE 9.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Identify and use applicable research and practice-based information for program development and implementation.

Purpose & Significance

The purpose of this measure is to assess the health department's identification and use of research and practice-based information in its design of new processes, programs, or interventions or in revisions of existing ones. Health departments should be aware of practices that have been found to be effective through research or experience in other communities and incorporate them into their processes, programs, or interventions, as appropriate.

MEASURE 9.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Incorporation of research or practice-based information in the development of a new public health process, program, or intervention or revision to an existing process, program, or intervention. Each example must address:			
a. The research or practice-based information source. (A web link may be provided on the Documentation Form if at least a summary or abstract is publicly available.)	**For required element a:** The source of research or practice-based information could be formal, such as peer-reviewed journals, or informal, such as from a peer health department. Additional potential sources could include, for example, The Guide to Community Preventive Services, NACCHO Model Practices, "What Works for Health", the Trust for America's Health's Promoting Health and Cost Control in States initiative, literature reviews, consultants, academia, researchers, or other experts on a particular topic. Tribal health departments could select sources from, for example, the Indian Health Services (IHS) or other Tribal-specific sources. A web link to the research or practice-based information may be included on the Documentation Form if at least a summary or abstract of the information is publicly available. If it is not publicly available, a copy of the article or a screenshot that shows the abstract or summary will be provided. The example could be research produced by health department staff, but only if that research were peer reviewed.		
b. A new or revised process, program, or intervention that reflects the information in required element a.	**For required element b:** Incorporating research or the practice-based information could be accomplished during the development phase of a process, program, or intervention; or it could be accomplished as new information becomes available and modifications are made to an existing process, program, or intervention. Documentation could include, for example, annual reports, newsletters, or other program descriptions, along with a brief explanation of how the process, program, or intervention was created or revised based on the information in required element a. The Documentation Form could indicate whether the program, process, or intervention is new or revised based on the identification of research or practice-based evidence.		

MEASURE 9.2.1 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	5 years
c. A description of how the appropriateness of the research or practice-based information was considered for a particular group or community being served, or how the health department modified the process, program, or intervention as needed to be appropriate for the particular group or community being served. Examples must come from two different program areas, one of which is a chronic disease program or program that seeks to prevent chronic disease.	**For required element c:** The health department will provide a description of how it considered the particular group or population(s) being served by the process, program, or intervention and assessed whether the research or practice-based evidence is appropriate for, or could be adapted to fit, that population(s). For example, if a small or rural health department wanted to use a practice-based example of an intervention that was originally implemented in a large, urban community, they could consider what adaptations would make that example effective in their own jurisdiction. Or, for example, a research-based example of a health promotion effort designed for a specific cultural group could be adapted by the health department for a different population group. Reviewing the evidence-based or practice-based intervention with a cultural humility lens could also prompt adaptation to ensure that the message will resonate with the community. Documentation of the consideration could be described in, for example, meeting minutes, notes included in a checklist, or a memo. Because there may be limited availability of researched or practice-based evidence specific to Tribal communities, Tribal health departments could provide documentation of how research or practice-based evidence has been adapted to integrate cultural values, beliefs, or traditional healing practices of the Tribe.		

MEASURE 9.2.2 A:

Evaluate programs, processes, or interventions.

Purpose & Significance

The purpose of this measure is to assess the health department's capacity to conduct or support evaluations to assess the effectiveness or efficiency of its processes, programs, or interventions. Evaluation is a systematic method for collecting, analyzing, and using information to understand how well interventions are achieving their goals and how they could be improved. In both the public and private sectors, stakeholders often want to know whether the programs they are funding, implementing, voting for, receiving, or objecting to, are producing the intended effect (outcomes) and how well they are operating (implementation). Conducting evaluations informs future improvements to processes, programs, or interventions.

MEASURE 9.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Evaluation of a process, program, or intervention. If the evaluation was conducted by another entity, the health department must demonstrate its involvement in both the evaluation and in the process, program, or intervention being evaluated.	The intent of this requirement is to provide an example of an evaluation of how well a process, program, or intervention is being implemented (i.e., process evaluation) or if it is achieving its intended outcome (i.e., impact or outcome evaluation). The evaluation might also consider analyzing the impacts or implications of the process, program, or intervention on equity. While the evaluation does **not** need to be complex or costly, the example will show that quantitative **or** qualitative data were used to evaluate the process, program, or intervention. The health department does **not** need to be the entity that conducts the evaluation; documentation of an evaluation conducted on behalf of the organization would be sufficient. (In other words, the health department would document that they asked or contracted with another entity to conduct the evaluation or that they participated in the evaluation in some way, for example, by either helping to frame the design or reviewing the results.) The health department could also participate in a community-centered evaluation approach, in which community members are engaged in developing evaluation questions, collecting data, and interpreting and sharing results. **Documentation Examples** Documentation could include, for example, an evaluation report or presentation, program or project report with evaluation findings submitted to a funding organization, or other summary evaluating a process, program, or intervention.		

MEASURE 9.2.3 A:

Communicate research findings, including public health implications.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to keep others, both within and outside the public health profession, informed about the findings of public health research and the public health implications of those findings. Public health research provides the knowledge and tools that people and communities need to protect and improve their health. However, research findings can be confusing and difficult to translate into knowledge that steers action toward improved public health. Health departments can communicate the facts and implications of research so that individuals and organizations are informed, knowledgeable and can act accordingly.

MEASURE 9.2.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Public health implications of research communicated to external stakeholder(s). Each example must include:	The intent of this requirement is to show how the health department has reviewed research to identify the implications or impact on public health and communicated those implications to external stakeholders. Research is defined as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. Research in the context of this measure is characterized as being peer-reviewed or validated by experts (validated means it was reviewed by an advisory board or expert review panel) to ensure accuracy and valid conclusions. This includes, for example, peer-reviewed articles or publications in research journals or reports such as those released by the National Academy of Medicine that incorporate a review panel in their development. Providing raw data, program reports, state/Tribal/community health assessment, county health rankings, or other statistical or analytical reports that have not undergone an expert review process would **not** meet the intent of this requirement. As long as the research has been peer-reviewed or validated, the research could have been produced by health department staff, but it does **not** need to be.		
a. A citation or other evidence that the research was peer reviewed or validated by experts.	**For required element a:** The communication will provide a citation for the research. If the citation is for a peer-reviewed journal, that will be considered evidence that the research was validated by experts. If the research is not from a peer-reviewed journal, the documentation could include, for example, the page in the report that describes the review panel process.		
b. The public health implications of the research.	**For required element b:** Implications of research could include, for example, an explanation of how the research might influence public health interventions or a description of the consequences of public health policy on equity. Implications could be communicated through, for example, a presentation, prepared report, discussion at a meeting recorded in the minutes, web posting, email list-serve, newspaper article, webinar, or press release.		
c. How the implications were communicated to one or more external stakeholders.	**For required element c:** Audiences could include, for example, the health department's governing entity; elected or appointed officials; agencies, departments, or organizations that collaborate with the health department in the delivery of services; community and healthcare partners; and the general public. Audiences would be especially appropriate if involved in or affected by the research. Community Based Participatory Research is an example of an approach that could be used.		

MEASURE 9.2.4 A:

Foster innovation.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to promote and support innovations in public health practice. Public health addresses complex, multi-sectoral problems that are changing as rapidly as our social, cultural, and technological environment is changing. The need for innovation in public health practice is urgent, given the increasingly rapid pace of change in the environment that affects the public's health.

MEASURE 9.2.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Effort to foster innovation skills, practices, or processes.	Public health innovation looks at and responds to unmet needs through the creation and implementation of a novel process, policy, product, program, or system. Public health innovation is intended to lead to improvements that impact health and equity. The intent of this requirement is to demonstrate one or more steps the health department has taken to encourage innovation. The example will focus on **how** the health department has fostered innovation. Providing an example of a program that the health department considers innovative would **not** meet the intent, unless the example described the process by which the team came up with an innovative approach. Steps could include, for example, offering trainings to staff on innovation, using approaches like design thinking to tackle problems, encouraging staff to develop prototypes to test new ideas, demonstrating leadership commitment to creativity and an understanding that failure may be part of the innovation process, or collaborating with teams for co-production with people with lived experiences who will be affected by the results of the innovation. (See the Public Health National Center for Innovations, a division of PHAB, for additional examples of strategies to foster innovation, as well as public health innovation's definition and tenets.) **Documentation Examples** Documentation could include, for example, training content, meeting minutes, project notes, or policies or initiatives to foster innovation (e.g., establishing a process to incubate novel projects).		

MEASURE 9.2.5 T/S:

Foster research.

Purpose & Significance

The purpose of this measure is to assess the **Tribal or state health department's** efforts to promote research in areas that are high priority to public health practice. A strong evidence base is needed to provide health departments with insights to inform practice. Collaborations provide opportunities to ensure research is conducted in the areas that are most relevant for the community.

MEASURE 9.2.5 T/S **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Involvement with other researchers to foster research.	The intent of this requirement is that the Tribal or state health department be involved with other researchers (e.g., a practice-based research network; community based participatory research network; other states, Tribes, or local jurisdictions; or educational or research institutions) to foster public health research. This could include, for example, the development, revision, or dissemination of a list of prioritized research topics/questions (i.e., a research agenda); providing mini grants to support students or researchers to conduct research on public health topics; or sponsoring or co-sponsoring a conference or other opportunities for researchers to present their findings. The intent of this requirement is to encourage the production of public health research. A collaboration with another institution on a single research study would **not** meet the intent of this requirement. However, if the health department documents its involvement in an ongoing relationship (for example, through an interagency agreement, memorandum of understanding, or academic health department agreement) with an academic institution or other researchers to conduct a series of research studies or evaluations, it would meet the intent. For Tribal health departments, this may include the incorporation of practice-based evidence grounded in cultural values, beliefs, and traditional practices. Tribal health departments may demonstrate participation in research conducted by larger Tribes, Tribal Epidemiology Center (TEC), the NIHB, and others who identify research needs and interests relative to improving the health of Americans Indians and Alaska Natives. **Documentation Examples** Documentation could include, for example, a membership list or meeting attendance roster, meeting minutes, a research agenda (with an indication in the documentation or the Documentation Form about the health department's involvement in its development) or an academic health department agreement with a plan to conduct a series of studies.		

MEASURE 9.2.6 S:

Provide support to Tribal and local health departments in applying relevant research results or evidence–/practice–based learnings.

Purpose & Significance

The purpose of this measure is to assess the **state health department's** process to provide support to Tribal and local health departments on the application (including interpretation and adaption) of relevant research results and evidence-/practice-based learnings. Scientifically sound public health practices are essential for public health interventions to be effective. Public health practices are continually being researched and tested, and new findings are being made available to the field. State health departments should share their knowledge and expertise concerning research findings and evidence-/practice-based learnings with Tribal and local health departments, based on the needs of those health departments. State health departments can provide other types of support on employing research and modifying practices to best suit the population served by the Tribal or local health department.

MEASURE 9.2.6 S: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Input requested from Tribal or local health departments on their needs for support in interpreting, adapting, or applying relevant research results or evidence-/practice-based learnings. If Tribal health departments are located within the state health department's jurisdiction, the example must reflect opportunities offered to **all** Tribes to provide their input on their needs.	The intent of this requirement is that state health departments have a process to understand what technical assistance, advice, direction, or guidance Tribal or local health departments would find relevant. Input on Tribal or local health departments' support needs could be gathered through, for example, surveys on research topics or subject areas or conversations, such as Council or Nations leadership, or other meetings. The documentation will include an opportunity for the Tribal or local health departments to provide feedback. If the state health department can document that it asked for feedback, it is **not** necessary to demonstrate that feedback was received. The state health department **cannot** use examples of seeking information about program divisions within the state health department's central office and their needs. In a centralized state, the examples could be information from or about the staff serving local jurisdictions and to Tribal health departments. **Documentation Examples** Documentation could include, for example, evidence of a survey disseminated to Tribal or local health departments, an email sent to Tribal and local health departments asking for a response about support needs, or meetings convened with feedback collected from Tribal or local health departments.		

MEASURE 9.2.6 S:	Guidance	Number of Examples	Dated Within
Required Documentation 2		2 examples	5 years
2. Support provided to Tribal **and** local health departments to be responsive to their needs concerning the interpretation, adaptation, or application of relevant research or evidence-/practice-based learnings. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state this must be indicated in the Documentation Form and two examples with local health departments must be provided.	The intent of this requirement is to show how the state health department provided support to Tribal and local health departments in the interpretation, adaptation, or application of research or evidence-/practice-based learnings within their own jurisdiction. Support could be provided by, for example, providing access to libraries of peer-reviewed research, providing access to journal articles, or connecting Tribal or local health departments with research institutes or academic partners. The state health department **cannot** use examples of providing support to program divisions within the state health department's central office. In a centralized state, the examples could be providing support to staff serving local jurisdictions or to Tribal health departments. Examples could be related to the activities described in Required Documentation 1, but do **not** need to be. The state health department may not be able to meet all the needs of local or Tribal health departments or respond to all their requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful and that recognition of Tribal sovereignty was considered in communication or decision making. If the example does not indicate how the support is responsive to Tribal or local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is **not** required. The Documentation Form could describe, for example, a request for assistance made by the Tribal or local health department on a phone call or through an email. This could be related to the activities described in Required Documentation 1, but it does **not** need to be.		

DOMAIN 10

Build and maintain a strong organizational infrastructure for public health.

Domain 10 focuses on the health department's capacity to maintain a strong organizational administrative structure. It includes maintaining and enhancing human and other organizational resources to support achievement of the health department's goals. Health departments must have a well-managed human resources system, be competent in general financial management, and have information management capacity. And, because of the nature of public health – the focus on the collective good, the use of government action, and the objective of population-based outcomes – public health leaders need an infrastructure to ensure that decisions, policies, plans, and programs are ethical and address equity. Health department leaders and staff must be knowledgeable about the structure, organization, and financing of their public health department.

The health department's engagement with its governing entity is essential to maintaining and strengthening the public health infrastructure for the jurisdiction served. Governing entities both directly and indirectly influence the direction of a health department and should play a key role in accreditation efforts. Variation exists regarding the structure, definition, roles, and responsibilities of governing entities.

DOMAIN 10 INCLUDES **THREE** STANDARDS		
Standard 10.1:	Employ strategic planning skills.	
Standard 10.2:	Manage financial, information management, and human resources effectively.	
Standard 10.3:	Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision-making, and governance.	
FOUNDATIONAL CAPABILITY MEASURES:		
Organizational Competencies	**10.1.2 A:**	Adopt a department-wide strategic plan.
	10.2.2 A:	Maintain a human resource function.
	10.2.3 A:	Support programs and operations through an information management infrastructure.
FOUNDATIONAL CAPABILITY MEASURES:		
Organizational Competencies	**10.2.4 A:**	Protect information and data systems through security and confidentiality policies.
	10.2.6 A:	Oversee grants and contracts.
	10.2.7 A:	Manage financial systems.
	10.3.3 A:	Communicate with governance routinely and on an as-needed basis.
	10.3.4 A:	Access and use legal services in planning, implementing, and enforcing public health initiatives.
Equity	**10.2.1 A:**	Manage operational policies including those related to equity.

STANDARD 10.1
Employ strategic planning skills.

Strategic planning is a process for defining and determining an organization's roles, priorities, and direction. A strategic plan sets forth what an organization plans to achieve, how it will achieve it, and how it will know if it has achieved it. The strategic plan provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities. A health department's strategic plan focuses on the entire health department. Health department programs may have program-specific strategic plans that complement and support the health department's organizational strategic plan; this standard addresses the health department's organizational strategic plan.

MEASURE 10.1.1 A:

Conduct a department-wide strategic planning process.

Purpose & Significance

The purpose of this measure is to assess the health department's strategic planning process. The development of a strategic plan requires a process that considers input and knowledge from across the health department and the governing entity, assesses the larger environment in which the health department operates, and leverages its organizational strengths to address identified challenges and opportunities.

MEASURE 10.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 strategic planning process	**Dated Within** 5 years
1. A department-wide strategic planning process, which must include:	The planning process may have been facilitated by staff of the health department or by an outside consultant.		
a. A list of the individuals who participated in the strategic planning process. Participants must include various levels of staff **and** representative(s) of the health department's governing entity or advisory board.	**For required element a:** The health department's size and organizational structure will define the various levels of staff engaged in the strategic planning process. The intent of this required element is that both leadership or management **and** non-managerial or frontline staff contribute towards the strategic planning process. In a centralized state, the state health department could include staff serving local jurisdictions, as appropriate. Participation could include, for example, contributing towards an environmental scan (components listed within required element b) or developing elements of the strategic plan, such as, the mission, vision, values, or strategic priorities. Sharing a final version of the strategic plan would **not** demonstrate the intent of this requirement. Similarly, presenting the final version to the governing entity for approval, would **not** meet the intent. While the health department does **not** need to engage the governing entity or staff in every strategic planning meeting, the intent is that at least one member from the governing entity or a liaison to the governing entity (e.g., a representative from the governor's or mayor's office) or advisory board **and** staff provide input during the development process to inform the final version. The documentation could be supplemented with an explanation in the Documentation Form to clarify participant titles and roles if, for example, the documentation (e.g., an excerpt for the strategic plan, meeting minutes) lists participants but does not include their titles.		
b. A summary or overview of the strategic planning process, which must include: i. The identification of the department's internal strengths and challenges. ii. The identification of external trends, events, or other factors that may impact community health or the health department.	**For required element b:** The strategic planning process could include use of a variety of tools or techniques, for example, brainstorming, stakeholder analysis, value stream mapping, storyboarding, or scenario development. The process could involve structured facilitation to assess, for example, the health department's strengths, weaknesses, opportunities, and challenges or threats (SWOC or SWOT), strengths aspirations, opportunities, and results (SOAR) analysis, or another environmental scanning process. Internal strengths and challenges generally include factors within the health department's control (e.g., staffing, technology, or financial management). External trends or events are outside of the health department's control with ramifications that could impact the health department's sustainability or programs/services (e.g., political or economic pressures, changes in the population's health status or socioeconomic status, or events).		

MEASURE 10.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 strategic planning process	**Dated Within** 5 years
iii. Consideration of capacity for or enhancement of workforce development, communication, financial sustainability, **and** information management or technology. iv. The process for selecting strategic priorities. If the health department is part of a super health agency or umbrella agency, the health department's process may have been part of a larger organizational planning process. If that is the case, the health department must have been actively engaged in the process and must provide evidence that public health was an integral component in the process. If not, then the health department must document that it has conducted a health department specific strategic planning process.	Critical components to sustain and enhance the effectiveness of the health department's infrastructure and operation include the health department's workforce development, communication (including brand strategy), finances, **and** information management or technology. Health departments could demonstrate consideration of the areas in iii by, for example, including them in strengths and challenges (i) or trends (ii), as appropriate; gathering feedback from staff or stakeholders about capacity or needed enhancements; including assessments of the health department's capacity (e.g., a workforce or technology assessment) in the items reviewed by the strategic planning participants; or providing information to the planning participants about what other health departments are doing in these areas. The health department's assessment of internal and external factors, as well as consideration of its capacity, informs the selection of strategic priorities. Methods to select priorities (iv) could include, for example, developing a list of potential goals and prioritizing among them through group voting, nominal group technique, or prioritization matrices. **Documentation Examples** Documentation could include, for example, meeting or strategic planning session materials (e.g., minutes or a presentation) or excerpt of the strategic plan.		

MEASURE 10.1.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Adopt a department-wide strategic plan.

Purpose & Significance

The purpose of this measure is to assess the health department's strategic plan. A strategic plan defines and determines the health department's roles, priorities, and direction over a set period of time. The strategic plan provides a roadmap to foster a shared understanding among staff to align towards contributing to what the department plans to achieve, how it will achieve it, and how it will know whether efforts are successful. The strategic plan takes into account leveraging its strengths, including the collective capacity and capability of its units towards addressing weaknesses and challenges. The strategic plan outlines the health department's contributions towards improving health outcomes outlined in the state/Tribal/community health improvement plan. The performance management system can be used to ensure the health department is on track with meeting the expectations in the strategic plan and quality improvement tools can help the health department meet its objectives.

MEASURE 10.1.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 strategic plan	**Dated Within** 5 years
1. A department-wide strategic plan, which must include:	The intent of this requirement is that the strategic plan outlines the health department's collective strategy for the future based on the assessment of internal organizational factors (e.g., strengths and opportunities based on capacity and capabilities) and external factors. Some health departments may have shorter planning timeframes and could produce a strategic plan more frequently (e.g., every three years). Some of the objectives in the plan could be for a longer time period than five years, but the plan will have been developed or revised within the last five years.		
a. The health department's mission, vision, and guiding principles or values.	**For required element a:** The mission reflects why the health department exists or the purpose of its collective units, services, or functions. A mission statement is a written declaration of the health department's core purpose and focus. The vision statement reflects the ideal future state (i.e., what the health department hopes to achieve). Guiding principles, or values, describe how work is done and what beliefs are held in common as a basis for that work.		
b. Strategic priorities.	**For required element b:** Strategic priorities outline what the health department plans to achieve at a high level in order to accomplish its vision. Strategic priorities could be called by a different name (e.g., strategic goals).		
c. Objectives with measurable and time-framed targets.	**For required element c:** Objectives with measurable and time-framed targets could be contained in another document, such as an annual work plan. If this is the case, the companion document will be provided with the strategic plan for this requirement. Objectives will be measurable and time-bound, and could be written, for example, in SMART or SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive and Equitable) form. Logic models may be used to support alignment of activities and outcomes and to demonstrate how these objectives help measure progress towards realizing the health department's mission.		
d. Strategies or actions to address objectives.	**For required element d:** Strategies or actions include steps the health department will take to achieve its objectives, in order to reach the intended outcome of the priorities. Strategies could be contained in a workplan outlining specific actions towards each objective and strategic priority. If in another document, the companion document will be provided with the strategic plan for this requirement.		

MEASURE 10.1.2 A: Required Documentation 1	Guidance	Number of Examples 1 strategic plan	Dated Within 5 years
e. A description of how the strategic plan's implementation is monitored, including progress towards achieving objectives, and strategies or actions.	**For required element e:** The intent of this required element is to describe how the health department monitors progress toward implementing the strategic plan, including objectives and strategies or actions, as identified in required elements c and d. Implementation of the strategic plan could be monitored, for example, through the performance management system, regularly scheduled meetings, or progress reports.		
f. Linkage with the community health improvement plan (CHIP). (If the linkage with the CHIP is not evident in the plan, it could be indicated in the Documentation Form.)	**For required element f:** Linkage could include, for example, strategic priorities aligned with priorities identified in the state/Tribal/community health improvement plan (CHIP). For example, if the CHIP has a priority related to reducing the infant mortality rate, the strategic plan might prioritize strengthening the health department's capacity to conduct surveillance related to maternal and child health in order to build its ability to support the partnership in this area.		
g. Linkage with performance management (PM). (If the linkage with PM is not evident in the plan, it could be indicated in the Documentation Form.)	**For required element g:** Linkage with performance management could include, for example, strategic plan priorities or activities that directly link to advancing a culture of quality or advancing use of performance management concepts or QI methods among staff. The linkage could also be demonstrated through explicit language about how the health department will use performance management to meet one of the strategic plan priorities (e.g., by specifying a plan to apply QI or performance management methods to meeting a priority related to expanding the health department's communications reach within the community) or to track progress on strategic plan objectives.		

MEASURE 10.1.2 A:	Guidance	Number of Examples	Dated Within
Required Documentation 1		1 strategic plan	5 years
If the health department is part of a super health agency or umbrella agency, the health department's strategic plan may be part of a larger organizational plan. If that is the case, the plan must include public health. At minimum, at least one of the strategic priorities must be relevant to public health. If not, then the health department must document that it has supplemented the agency plan to address required elements b-d **or** adopted a health department specific strategic plan that addresses required elements a-g.	For required elements f and g, the strategic plan does **not** need to link to all elements of the state/Tribal/community health improvement plan or performance management, but it will show where linkages are appropriate for effective planning and implementation. The Documentation Form could be used to clarify and describe linkages (required elements f and g).		

MEASURE 10.1.3 A:

Monitor implementation of the department-wide strategic plan.

Purpose & Significance

The purpose of this measure is to assess the health department's monitoring of and communication about strategic plan implementation. A strategic plan sets forth what the department plans to achieve as an organization, how it will achieve it, and how it will know if it has achieved it. It is important to regularly review the implementation of the plan to ensure that the department is on track to meet its targets. Engaging staff and the governing entity in this monitoring can support collective efforts to achieve strategic plan objectives.

MEASURE 10.1.3 A: Required Documentation 1	Guidance	Number of Examples 2 Examples	Dated Within 3 years (2 most recent reports)
1. Monitoring of progress towards **all** the strategic plan objectives. Reviews must be completed at least annually. If the plan has been adopted within the year of submission to PHAB, progress on a previous plan may be provided, or detailed monitoring plans may be submitted.	The intent of this requirement is to show monitoring of progress towards **all** objectives within the strategic plan. A review of one or a few objectives would **not** meet the intent. If no progress has been made on an objective, this can be indicated. It is not expected that all objectives would have been achieved, only that the health department is reviewing and monitoring the plan in its entirety at least annually. Monitoring may take place more frequently than annually (e.g., quarterly). Monitoring of the strategic plan provides opportunities to assess what strategies or actions have been completed, whether timelines or targets require adjusting, or if additional resources are needed to support implementation. **Documentation Examples** Documentation could include, for example, progress reports or presentations, or screenshots of a dashboard showing actual progress towards objectives.		

MEASURE 10.1.3 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 2 years
2. Communication with governance **and** staff at various levels concerning implementation of the strategic plan. One example must demonstrate sharing with staff and one example must demonstrate sharing with the governing entity or advisory board.	The intent of this requirement is that the health department informs at least one of its governing entities or advisory boards **and** both leadership/management and non-managerial/frontline staff on progress towards the implementation of the strategic plan. Regular communication fosters increased awareness of priorities and provides an opportunity for dialogue on the feasibility and effectiveness of priorities and objectives as the plan is implemented. In a centralized state, the state health department could include staff serving local jurisdictions, as appropriate. **Documentation Examples** Documentation could include, for example, meeting minutes, reports shared with the governing entity and staff, presentations, emails, or other discussion records.		

STANDARD 10.2

Manage financial, information management, and human resources effectively.

Sound financial, information management, and human resource practices are fundamental to any organization. A strong infrastructure depends on the health department's ability to oversee financial resources wisely, to maintain up-to-date policies, to manage human resources, and to ensure information technology is adequate and secure to support the work. The accessibility, cleanliness, safety, and security of physical facilities is important for both staff and the communities served by the health department.

MEASURE 10.2.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Manage operational policies including those related to equity.

Purpose & Significance

The purpose of this measure is to assess the health department's process for reviewing, revising, and sharing health department policies and procedures with staff, as well as the incorporation of inclusion, diversity, equity, and anti-racism principles in department-wide policies or initiatives. Standardized policies and procedures ensure consistency across the health department's operations to support the organization's efficiency and effectiveness. Staff need to have ready access to policies and procedures to be informed of organizational and operational expectations. Department-wide policies, declarations, or initiatives related to inclusion, diversity, equity, or anti-racism principles can help infuse those concepts throughout the health department, including in its internal operations. An important first step in those initiatives is having a common understanding of the terminology related to equity.

MEASURE 10.2.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years
1. Operational policies or procedures that are:	Operational policies are intended to direct the operations of the health department as a whole. Program policies would **not** meet the intent of this requirement. While HR, personnel, and confidentiality policies could be contained within one comprehensive operational policy manual, these policies are specifically covered in other measures and submitting those policies alone would **not** meet the intent of this requirement. Operational policies or procedures could address, for example, records retention and back-up procedures; reimbursement; invoicing; emergency/evacuation procedures for the office; events planning; procurement of office supplies; facilities operations; use of department equipment (e.g., including phones and internet); use of department vehicles; in-office tobacco use; recycling; scheduling the use of meeting rooms; or development of policies including who needs to sign what types of policies and how often they are reviewed (e.g., a policy on policies). Health departments could use policies or procedures that are not specific to the health department, but are government-wide (i.e., Tribe, state, city, or county) or relate to a larger super health agency or umbrella agency. These policies or procedures could demonstrate conformity with the measure if they apply to the health department's operations. In these instances, the example for required element a could show how the health department reviewed and provided input on suggested changes to the agency that sets the policy.		
a. Reviewed and revised on a routine basis.	**For required element a:** Official dates of policy or procedure revisions demonstrate that a review has been conducted within the last five years. This could be demonstrated by, for example, an operational policy or procedure with revised date, or an email sent to staff with the revised policy or procedure.		
b. Accessible to staff. (If the method(s) for staff access is not evident in the example, it could be indicated in the Documentation Form.) The examples must be for **operational** policies. In a centralized state, for required element b, the state health department must demonstrate **operational** policies that are applicable to staff serving local jurisdictions are accessible to those staff.	**For required element b:** Methods for staff access could be described in the Documentation Form or demonstrated through, for example, screenshots of a shared file folder or intranet page, emails to staff with the file location or revised policies or procedures attached, or photos of the location where staff can access hard copy versions.		

MEASURE 10.2.1 A: Required Documentation 2	Guidance	Number of Examples 1 list of terms with definitions	Dated Within 5 years
2. Adopted definitions of equity terms.	The intent of this requirement is that the health department will determine what definitions it will use for terms related to inclusion, diversity, equity, or anti-racism in order to establish a common understanding among staff and set the context for department-wide efforts. The health department will provide definitions of multiple equity-related terms, but the health department will determine which terms to define. Terms could include, for example, inclusion, diversity, equity, or anti-racism. The health department could use definitions established by others (e.g., definitions provided in the PHAB glossary, national or state organization, or community coalition), or it could engage staff in developing its own definitions that are relevant in the jurisdiction. Input from diverse participants is valuable in developing definitions and ensuring that they are meaningful to all staff. Documentation that terms have been adopted could include, for example, an excerpt from the strategic plan, communications plan, workforce development plan, memo, poster, or minutes from a staff meeting in which definitions were discussed and agreed upon.		

MEASURE 10.2.1 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 5 years
3. Department-wide policy, declaration, or initiative that reflects specific intention focused on inclusion, diversity, equity, or anti-racism.	The intent of this requirement is that the health department demonstrate how inclusion, diversity, equity, or anti-racism (IDEA) concepts are integrated throughout the department. An example that is applicable only to a specific program in the department would not meet the intent. The example could address, for example, a department-wide policy about health equity as a guiding foundational principle or core value underlying all policies or operations; including IDEA as part of the health department's mission, vision, or values; declaration of racism as a public health emergency; or a department-wide focus on diversity and inclusion in recruiting participants in programs, advisory groups, and staff. The initiative could also focus on the internal operations of the health department by, for example, including an equity lens in contracting, purchasing, and budgeting procedures; implementing processes to consider power in internal decision making; or integrating equity concepts in human resources policies. Input from diverse participants is valuable in adopting and revising such policies. While the definitions from Required Documentation 2 could be part of this example, the definitions alone would **not** meet the intent of this requirement.		

MEASURE 10.2.2 A:

FOUNDATIONAL CAPABILITY MEASURE

Maintain a human resource function.

Purpose & Significance

The purpose of this measure is to assess the health department's policies related to human resources. A well-defined and structured human resource function is important to support the workforce, which is the most critical asset of any organization. It provides the health department's hiring, management, and personnel performance evaluation processes. A human resource function supports the health department, individual staff members, staff development, and the overall workplace environment.

MEASURE 10.2.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 set of policies or procedures	**Dated Within** 5 years
1. Human resources policies or procedures that address each of the following:	A comprehensive human resource function could be fully contained within the health department, located in a different governmental agency (e.g., an office of management), or implemented in a combination of ways. Health departments could use a human resource system, including policies and procedures, that is government-wide (i.e., Tribe, state, city, or county). A health department could also contract for certain human resource actions to an outside organization that specializes in human resource management functions. These policies could demonstrate conformity with the measure if they apply to the health department.		
a. Personnel recruitment, selection, **and** appointment. b. Equal opportunity employment.	**For required elements a and b:** For Tribal health departments, Indian Preference Policies may be submitted in place of personnel selection and appointment and/or Equal Opportunity Employment policies. It may also be applicable that Tribal health departments provide MOAs for assignment of personnel (e.g., U.S. Public Health Service/Indian Health Service or other personal service contracts or agreement (PSA).		
c. Confidentiality of employee information and personnel records.	**For required element c:** The requirement is referring to employee records (i.e., policy on confidentiality of employee records); it is **not** referring to expectations regarding HIPAA or protecting client health information.		
d. Salary structure. e. Benefits package.	**For required elements d and e:** Salary structure and benefits refer to employee compensation. Salary (i.e., pay, income, or wage) structures might include pay scales or ranges of pay based on position. Benefits might include, for example, insurance (e.g., health, disability, dental, vision, or life), paid time off or paid holidays, retirement planning, family leave, remote work or flexible schedules. In addition to the salary structure and benefits package, the health department could also consider how it assesses employee compensation to ensure the health department's offerings are competitive or whether compensation has been adjusted to account for inflation or cost of living.		
f. Performance evaluation process based on either job/position descriptions or annual objectives.	**For required element f:** Performance evaluation processes could include, for example, annual reviews, or 360 evaluations. The intent of this required element is that the health department demonstrate reviews are conducted based on merit and evaluate employee performance according to position expectations or requirements.		
g. Process for handling **and** resolving complaints from or about staff, which must minimally include provisions for protection against retaliation **and** for complaints related to sexual harassment.	**For required element g:** Policies or procedures could address, for example, use of an ombudsman, civil service commission, or internal processes for staff to report complaints, including sexual harassment, in a confidential manner, free from concerns of retaliation, as well as processes for how they are resolved.		

MEASURE 10.2.3 A:

FOUNDATIONAL CAPABILITY MEASURE

Support programs and operations through an information management infrastructure.

Purpose & Significance

The purpose of this measure is to assess the health department's process for improving information management infrastructure. Well-designed and managed information management systems support the health department's work to achieve its mission and support its workforce in planning and evaluating its efforts to improve the health of the population. Continuous advancements in information management technologies require processes to identify needed enhancements or replacements.

MEASURE 10.2.3 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
1. A process for how the health department determines what updates, enhancements, or replacement of information management systems are needed. The process must, at minimum, include:	The intent of this requirement is to demonstrate how the information management infrastructure supports programs and operations. In addition to how staff request changes to information management systems, the process could include, for example, conducting an assessment of technology needs on a routine basis, planning to ensure information technology is able to address emerging public health needs, or keeping apprised of technology updates being implemented in other health departments. Health departments could use a government-wide (i.e., Tribal, state, city, or county) or super health agency or umbrella agency process. These processes could demonstrate conformity with the measure if they apply to the health department. It is possible that there are multiple processes used for staff requests and review (e.g., one process by which individual employees request updates to hardware or software to ensure they can perform their job functions and a separate process for how program staff request larger information systems upgrades). In that case, only **one** process is needed, even if it does not cover the health department's full scope of processes for information systems improvements.		
a. How staff make requests.	**For required element a:** This process does **not** need to be complicated but will describe the process in place whereby staff could request, for example, bugs or system errors to be fixed; enhancements or updates to existing systems to ensure they are adequately supporting program functions; or replacement of an existing information management system that has become outdated or unsupported.		
b. How those requests are reviewed.	**For required element b:** The process for how those requests are reviewed could describe, for example, how the requests are prioritized in alignment with the goals in the health department's strategic plan or state/Tribal/community health improvement plan. **Documentation Examples** Documentation could include, for example, a standard operating procedure, request form template, or flow chart.		

MEASURE 10.2.4 A:

FOUNDATIONAL CAPABILITY MEASURE

Protect information and data systems through security and confidentiality policies.

Purpose & Significance

The purpose of this measure is to assess how the health department protects the security of its data systems and confidential information. Adopting an information security policy is a critical step in supporting the health department's efforts to ensure data are protected from risks and potential threats, including ransomware attacks. Health departments should maintain protections for safe and redundant storage, handling, and access to classified, confidential, and sensitive information (e.g., client records, surveillance data, and human subjects research sensitive information). Lack of attention to privacy and security controls can lead to breaches in federal, state, or local laws; diminished credibility or trust among community members; and vulnerabilities in maintaining operations and provision of services.

MEASURE 10.2.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or set of policies	**Dated Within** 5 years
1. A department-wide information security policy that includes the following:	The health department will base their policies on applicable laws, rules, regulations, and funder requirements. While the policy will minimally include the required elements, it may also include additional information security policies, such as a ransomware or cybersecurity policies. The intent of this requirement is **not** confidentiality of employee records. Health departments could use government-wide (i.e., Tribe, state, city, or county) or super health agency or umbrella agency policies and procedures. These policies and procedures could demonstrate conformity with the requirement if they apply to the health department.		
a. A description of the requirements for password complexity **and** lifespan.	**For required element a:** Password complexity and lifespan are some of the first lines of defense against information security risks. The information security policy will include guidance and expectations for password complexity, as well as lifespan of passwords or established password expiration timelines.		
b. A process for ensuring physical security of information **and** network security.	**For required element b:** Physical security of information requires processes to ensure that information is not accessed by unauthorized parties. Physical security could be maintained through, for example, the use of a secure server room; locked doors or windows; video surveillance; limited access among key staff; device and endpoint management; or protections for environmental hazards (e.g., climate-controlled secure server rooms or use of surge protectors). Network security might include critical infrastructure cybersecurity, cloud security, redundant data backups, use of firewalls, security software to detect malware or viruses, or routine program and system updates.		
c. A policy for data that require additional privacy protection, which includes: i. A process for identifying such data, which must, at minimum, include all data that are covered by applicable federal, state, and local privacy protection regulations for handling confidential data.	**For required element c:** The process for privacy protection could be part of a separate policy. Confidentiality policies could address processes for handling, storing, managing, and disposal of confidential data, which could include, for example, Protected Health Information (PHI) as regulated under Health Insurance Portability and Accountability Act (HIPAA), Personally Identifiable Information (PII), Sensitive Identifiable Human Subject Research regulated by the Federal Policy for the Protection of Human Subjects (or "Common Rule"), or other sensitive information, in accordance with laws, rules, and regulations within the health department's jurisdiction. i. Knowing which data are sensitive or mission-critical allows the health department to establish appropriate security controls for those data and systems. As appropriate, the health department could classify an entire system (e.g., a surveillance system) or it could classify certain fields within the system. Classifications could include, for example: ▪ Sensitive data are data that are not meant to be made public. Sensitive data systems could include, for example, immunization data registries, reportable disease records, or vital records. ▪ Mission-critical data are any data or systems that, if compromised or unavailable to users for long periods of time, would prevent the health department from being able to conduct its business functions. Mission-critical data or systems could include, for example, systems for collecting payment for environmental health licenses or permits. Policies for maintaining mission-critical data may include, for example, more frequent redundant data backups.		

MEASURE 10.2.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or set of policies	**Dated Within** 5 years
iii. A process for maintaining confidentiality of data that are stored as paper versions, as appropriate.	ii. User access management refers to the process for ensuring only users who need access to sensitive and mission-critical data and data systems are granted access to those data and systems. The policy could describe processes for, for example, determining appropriate users, ensuring those users are the only ones with access, and disabling the access of users who do not require access to sensitive and mission-critical data and systems.		
ii. A process for user access management for electronic data and data systems.	iii. Confidentiality of paper versions of data could include, for example, use of locked file cabinets or storage areas/facilities, restricted access among key personnel, or disposal of confidential or protected health information in accordance with HIPAA.		

MEASURE 10.2.4 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 2 years
2. Evidence that all staff have participated in information security training, which at a minimum includes:	Training could be provided through in-person trainings or presentations, webinars, online courses, simulations, or other formats. Additional information security training, such as physical security, may be necessary for some staff positions within the health department. The health department does **not** need to be the entity providing the training. For example, a Tribal health department could provide documentation of policies and training on confidentiality that was managed by the health care side of the Tribe's work, as long as the health department staff were included in the training.		
a. Password best practices.	**For required element a:** Training about password best practices could include, for example, password complexity, password length, types of characters included in passwords, frequency of updating passwords, not using the same password for all accounts, and not having a paper document or file that lists all passwords.		
b. Cybersecurity. Documentation must include evidence of training content **and** how the health department tracks staff participation in the training.	**For required element b:** Cybersecurity topics could include, for example, phishing, pharming, or other cyber attacks. Phishing occurs when a target is contacted by email, telephone, or text message by someone posing as a legitimate institution to lure individuals into providing sensitive data (e.g., personally identifiable information, banking and credit card details, or passwords). Pharming is a fraudulent practice that redirects a website's traffic to a fake site that mimics the appearance of a legitimate site. It is important that health department staff are trained on how to avoid falling victim to cybercrimes. **Documentation Examples** Documentation could include, for example, a copy of the training materials along with spreadsheets, screenshots from a learning management system, sign-in sheets, or a log. Evidence will show the health department has a process for tracking that all staff participate, but it is **not** required to include all employees in the example submitted to PHAB. (In other words, it is not necessary to include screenshots that show every staff person.) A signed acknowledgment of staff reviewing a policy alone would **not** meet the intent of training for this requirement.		

MEASURE 10.2.4 A: Required Documentation 3	Guidance	Number of Examples 1 form and evidence of tracking	Dated Within 5 years
3. Acknowledgement that **all** employees received confidential data handling policies, which includes:	The intent of this requirement is that the health department demonstrate mechanisms are in place to ensure confidentiality expectations are communicated and **all** staff are aware of the expectations.		
a. A confidentiality form or agreement that is signed by employees.	**For required element a:** The form or agreement serves as an acknowledgement among employees of their responsibilities for protecting confidentiality. The health department can submit a copy of the form or agreement template used by the health department. The actual forms or agreements signed by all employees are **not** required.		
b. Evidence the health department tracks that all employees have signed the confidentiality form or agreement.	**For required element b:** The intent of the required element is to demonstrate the health department has a process to ensure that all employees have signed the confidentiality form or agreement. This could be, for example a record or log with columns indicating when employees signed the confidentiality form or agreement. **Documentation Examples** One blank confidentiality form and a completed tracking mechanism, which could include, for example, a spreadsheet noting the dates all staff signed the confidentiality form, or screenshots of a software program or system that shows signed forms from all staff. Evidence will show the health department has a process for tracking that all staff participate, but it is **not** required to include all employees in the example submitted to PHAB. (In other words, it is not necessary to include screenshots that show every staff person.)		

MEASURE 10.2.5 A:

Ensure clean, safe, accessible, and secure facilities.

Purpose & Significance

The purpose of this measure is to assess the health department's improvement of facilities for use by both staff and the public, as well as the accessibility of services held offsite. Facilities must be adequate in order for the health department to implement programs and interventions. All facilities that are operated by the health department must be clean, safe, accessible, and secure for both staff and the public. Improvements might be based on staff or customer complaints, or more formal assessments (e.g., OSHA, ADA, security assessments).

MEASURE 10.2.5 A: Required Documentation 1	Guidance	Number of Examples 1 example	Dated Within 5 years
1. An improvement made to address the health department's physical facility(ies) related to cleanliness, safety, accessibility, or security. Alternatively, the health department can provide assessment results demonstrating no physical facility improvements were needed.	The improvements could be demonstrated, for example, through completed work orders for facility improvements, or photos with a description of the work performed. Renovations that are purely aesthetic would **not** meet the intent of this requirement. Other examples of documentation could include, for example, environmental public health and safety committee meeting minutes, federal or Tribal environmental audits, or meeting minutes discussing and/or facility improvements.		

MEASURE 10.2.5 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. Assurance of accessibility to health department's facilities or services when services are provided offsite or in a temporary location. If the health department has not provided services in an offsite or temporary location in the past five years, this must be indicated to PHAB and **no** documentation is needed for this requirement.	The intent of this requirement is that the health department consider accessible services provided in offsite or temporary locations, based on Americans with Disabilities Act (ADA) requirements. This requirement does **not** address permanent health department facilities. The intent is to demonstrate accessibility of temporary or intermittent offsite locations, which could include, for example, drive-thru medical services, pop-up tents, use of vacant parking lots (e.g., vaccine or supply distribution), community centers or schools (e.g., flu vaccine clinics), or community kitchen or garden (e.g., nutrition class). Documentation could demonstrate actual or planned use of offsite or temporary locations considering accessibility, for example, by engaging the disability community (e.g., Centers for Independent Living, individuals with disabilities, or local organizations). Accessibility design aspects could consider, for example, wheelchair access, use of service animals, or appropriate signage for the deaf, blind, or hearing impaired, such as, use of braille, separate tactile or raised lettering, use of pictograms or visual aids. Documentation could include, for example, meeting minutes that include a discussion of accessibility when considering location; email chain with another location to ask accessibility questions; photos demonstrating accessibility; or copy of the ADA compliance report of the facility.		

MEASURE 10.2.6 A:

FOUNDATIONAL CAPABILITY MEASURE

Oversee grants and contracts.

Purpose & Significance

The purpose of this measure is to demonstrate accountable financial stewardship and oversight of agreements with other organizations. This includes the health department's ability to demonstrate its use of funds provided through grants and contracts, as well as the health department's monitoring of organizations that provide services, programs, or interventions on behalf of the health department. Health departments receive funding from a variety of sources. Each funding source has specific requirements for the use of the funds and for reporting to the funding agency. It is important that funds are used appropriately and legitimately, and that the health department has systems for accountability.

MEASURE 10.2.6 A:

Required Documentation 1

Guidance

Number of Examples
2 examples

Dated Within
5 years

1. Program reports submitted by the health department to funding organizations.

Reports submitted to funders must show progress made with resources provided.

Examples must be from two different program areas.

The intent of this requirement is to show evidence of implementation of deliverables using resources provided to the health department. Contracts or agreements may show the expectations for how the health department will use resources but would not meet the intent of this requirement unless they include documentation of how the health department has made progress with the resource(s) provided. Resources may include funding or other items provided to the health department. For example, if the health department received car seats, the example could show reports to the donor entity showing the health department distributed them appropriately in the community.

Documentation Examples

Documentation could include, for example, compliance reports to state or federal funders, reports to legislatures or local city/county/Tribal councils, or reports to foundations. Monitoring reports or corrective action plans that show compliance with funding requirements are also acceptable.

MEASURE 10.2.6 A:

Required Documentation 2

Guidance

Number of Examples
All, as appropriate

Dated Within
5 years

2. **All** formal communications from state or federal funders that indicate the health department is a "high-risk grantee."

Disclosure and documentation must be provided in the following types of instances: the department being put on manual draw-down; the department being put on a corrective action plan; the department being place on provisional status; placement on a 'do not fund' list; receivership status; and instances of malfeasance or misappropriations of funds.

Documentation must include a description of follow-up actions or internal controls in place to facilitate resolution of the situation.

If there have been no communications regarding "high-risk grantee" status, the health department must provide a statement signed by the director, a deputy or assistant director, or a finance officer attesting to that fact.

Documentation could include, for example, letters or emails that officially and formally describe concerns from funding agencies (e.g., federal agencies, state health department funding to local health departments), as well as the steps taken to facilitate resolution.

The signed statement attesting to the health department not being a high-risk grantee could be, for example, as simple as a signed memo from the health department director, a deputy or assistant director, or a finance officer. In this instance, no further documentation is required (i.e., it is **not** necessary to describe follow-up actions).

MEASURE 10.2.6 A:	Guidance	Number of Examples	Dated Within
Required Documentation 3		2 examples	5 years

3. Signed agreements with organizations outside the health department that outline how those other organizations will provide services, programs, or interventions **on behalf of** the health department.

The examples must be from two different areas.

Each example must feature a written agreement with a different organization where the other organization is agreeing to provide a service, program or intervention on behalf of the health department.

Only one example can be with another health department.

The intent of this requirement is to provide contracts or agreements for which the health department has an oversight or contract management role; mutual aid agreements that do not have this oversight component would **not** meet the intent. Contracts may be current and unexpired at the time of submission or may have been executed within the timeframe requirement and since expired. If the health department is part of a super health agency or umbrella agency that manages all contracts, the examples can be managed by the umbrella agency.

Documentation Examples

State health department documentation could include, for example, a written agreement with a local or district health department for one of the examples.

Local health department documentation could include, for example, a written agreement with another local health department for one of the examples, as long as the other health department is providing a service on behalf of the local health department. For example, if the health department manages a written agreement with a neighboring health department for that neighboring health department to provide epidemiology services, it would meet the intent of this requirement. Examples of cross-jurisdictional sharing whereby the health department does not have contract management or oversight of the written agreement would **not** meet the intent.

Other examples could include, for example, a contract for translation services, contract for IT service, an MOU with another entity to provide cooking classes to a population group served by the health department, or MOU with a college to conduct research on behalf of the health department.

Tribal health department documentation could include, for example, a written agreement with a local, district, or state health department for one of the examples. Tribal health departments could use the compact or funding agreement with the U.S. DHHS to carry out programs of the Indian Health Service. Acceptable documentation could also include, for example, agreements with non-Tribal entities to provide Contract Health Services (CHS) to beneficiaries of the Tribal health department, or MOA/MOUs or other agreements for epidemiological services provided to Tribes from Tribal Epidemiology Centers.

MEASURE 10.2.6 A: Required Documentation 4	Guidance	Number of Examples 1 example	Dated Within 5 years
4. Improvement made to the health department's processes for managing written agreements with other organizations **or** for demonstrating compliance with requirements from its funders.	The intent of this requirement is to demonstrate an improvement made to processes related to written agreements, contracts, or grants. This could include, for example, standardizing or improving processes for receiving invoices and paying contract fees and invoices on time; receiving reports from contractors and ensuring services are rendered; receiving resolution of corrective action reports from a contractor if services are not rendered; or otherwise holding others accountable for compliance with agreements to the health department. Examples could also include, for example, steps the health department is taking to improve its processes for monitoring and reporting on work the health department does as part of meeting funding requirements (e.g., spend-down processes). Improvements do **not** need to be complicated, but could include, for example, assessing timeliness of payment by calculating the proportion of invoices paid on time and using data to identify areas to improve efficiencies, increasing accuracy in accounting and budgeting processes, implementing a process to evaluate reports received from contractors for services rendered, establishing a process to conduct a comparison with the scope of work or expected deliverable, or establishing a process for requiring a corrective action report if services are not rendered. **Documentation Examples** Documentation could include, for example, improvements discussed during a meeting or summarized in a report or quality improvement project.		

MEASURE 10.2.7 A:

FOUNDATIONAL CAPABILITY MEASURE

Manage financial systems.

Purpose & Significance

The purpose of this measure is to assess the health department's processes for financial reports and audits. Sound management of financial resources is a basic function of a health department. Health departments are accountable to funders, their governing entity, elected officials, and the public they serve for the responsible use and oversight of funds.

MEASURE 10.2.7 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 2 years
1. Quarterly (or monthly) financial reports. This measure requires department-wide financial reports, **not** single program reports. Reports must contain both revenues **and** expenses.	The examples provided could demonstrate two different types of reporting or could be two successive reports of the same type. Reports will be at least quarterly, though more frequent reports, such as monthly reports, are acceptable. Financial reports for one program would not meet the intent of the requirement, which is to demonstrate financial reports for the entire department. **Documentation Examples** Documentation could include, for example, detailed revenue and expenditure reports by program area, using the Uniform Chart of Accounts or other dashboard frameworks, reports to governing entities, or monthly budget reports.		

MEASURE 10.2.7 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 5 years (two most recent audits)
2. External department-wide financial audit reports. The audits must be full health department audits (**not** single program audits).	The health department's audit could be part of a larger audit of the governmental unit (for example, umbrella agency, super agency, county government, or state government) of which the health department is a part. **Documentation Examples** Documentation could include, for example, county audit reports that include a section on the health department's finances, or a stand-alone, independent audit of the health department.		

MEASURE 10.2.7 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 3 years
3. Improvement steps identified based on findings from the most recent audit. If the most recent audit did not include findings to address (i.e., a clean audit), the health department must indicate that to PHAB and **no** documentation is needed for this requirement.	The example provided will include steps, or corrective actions, the health department is taking to address audit findings. A summary of steps identified or taken to address the findings will be accepted. The intent of this requirement is to show that the health department is planning steps to address findings in the audit. It is **not** necessary for those steps to have been completed by the time the documentation is submitted. Examples of improvement steps could include, for example, evaluating current processes to identify areas that need improvement, reviewing policies to ensure they comply with requirements, strengthening internal controls to improve timeliness or tracking requirements, providing training to staff on policies and regulations, or defining clear roles and responsibilities. The documentation could be supplemented with a description in the Documentation Form to clarify how actions are improvements based on the audit.		

MEASURE 10.2.8 A:

Evaluate finances and seek needed resources to support ongoing and emergent needs.

Purpose & Significance

The purpose of this measure is to assess the health department's activities to secure necessary financial resources, by conducting financial analysis, seeking new funds or increased efficiencies, and adapting financial practices to manage uncertain events. It is critical to continually work to secure financial resources to maintain and grow public health services provided to the community. Sources of funding that might be increased to meet the needs of the department include fees, fines, grants, contracts, per capita allocations, and the general fund.

MEASURE 10.2.8 A: Required Documentation 1	Guidance	Number of Examples 2 examples	Dated Within 5 years
1. Financial analysis of available resources **and** financial support needed to maintain and improve public health infrastructure or services in the jurisdiction served by the health department.	The intent of this requirement is that the health department compare resources and expenditures (broken down by services or program/administrative areas) for the purpose of communicating the need for financial support for the health department. Typically, financial analysis is used to analyze whether the department is stable, solvent, and liquid. Financial analysis does not need to be complicated. Financial analysis of available resources could include analysis of revenue sources or review of historical data and projections for the future. Standard financial analysis could include, for example, cost benefit of expenditures, expenditure trend analysis, historical funding trends, cash flow analysis, forecasting, accounts receivable, and inventory depreciation. It could also include, for example, comparison of service-specific or administrative-related resources and expenditures to other similar health departments by using the Uniform Chart of Accounts or other dashboard frameworks. Examples of analyzing those available resources related to the financial support needed could include, for example, analysis of allocations based on the health department's strategic priorities, state/Tribal/community health assessment, state/Tribal/community health improvement plan objectives, foundational public health services, prevention versus treatment programming, or other methods to evaluate returns on investment. The analysis could be created by the health department or by another branch of government (e.g., office of management and budget) as long as it is specific to public health infrastructure or public health services in the jurisdiction served by the health department.		

MEASURE 10.2.8 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
2. Formal efforts to seek additional financial resources or increase efficiencies. At least one example must show engagement with the governing entity that has financial oversight for the health department.	The intent of this requirement is that the health department made a formal effort to seek additional financial resources or to initiate a change to increase efficiencies. Additional funding to support public health programs and infrastructure could be sought through a variety of means, including, for example, budget increase requests, budget revision requests, or grants. Efforts could also address sustaining funding amid budget reductions (e.g., securing funding from another source to supplement maternal or child health programs in the event funding is reduced). Other examples could include, for example, letters or testimony about financial support needs. The health department could also demonstrate ways to decrease inefficiencies and cut costs while still maintaining needed services for the community, for example, through shared service agreements. The examples do not need to have been successful. Engagement with the governing entity could include, for example, requesting funding from that entity; communicating to the governing entity about the need for additional financial resources or efforts to increase efficiencies; or having the governing entity, in conjunction with the health department, communicate with others about the need for additional financial resources for the health department. While the health department will demonstrate engagement with the governing entity because of its role in financial oversight, the health department may also work with advisory boards (e.g., coordinating with advisory boards about messaging related to the need for financial sustainability).		

MEASURE 10.2.8 A: Required Documentation 2	Guidance	Number of Examples 2 examples	Dated Within 5 years
	Documentation could include, for example, grant applications (funded or unfunded); matching funds; requests to increase levies, taxes, or fees; or shared service agreements.		

MEASURE 10.2.8 A: Required Documentation 3	Guidance	Number of Examples 1 example	Dated Within 5 years
3. Flexible financial management during uncertain or unplanned events.	The intent of this requirement is to demonstrate how the health department has adapted its standard financial procedures to manage uncertain or unplanned events (e.g., disasters or unexpected increases or decreases in funding). Flexible financial management could ensure, for example, essential services will be resourced to sustain critical operations as identified in the COOP. Examples could include, for example, rapid program development and execution or program revision to address an unexpected event; the allocation of resources during an emergency to consider populations with higher health disparities and those disproportionately affected by unplanned events; or expedited written agreements with other entities. The example could show how the health department demonstrated flexibility in times of unexpected budget cuts or unanticipated increases in funding. If the health department operates as part of a super health agency or an umbrella agency, the example may be initiated as part of the broader agency, as long as the funding relates to public health services or operations.		

STANDARD 10.3

Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision–making, and governance.

The health department must maintain an organizational culture that promotes ethical integrity and equal dignity and respect in relationships among staff, with the outside community, and with the beneficiaries of the organization's public health programs and services. This is one component of the important objective of bringing about tangible change in the culture and practice of organizational management. Key values that the public health profession and public health organizations should promote and profess in the broader community should also be reflected within the culture, policies, and conduct of the organization, including incorporating into risk management ethical considerations that encourage transparency while ensuring individual privacy. (Public Health Code of Ethics, 2019).

Public health governing entities exercise a wide range of responsibilities, including policy development, resource stewardship, legal authority, partner engagement, continuous improvement, and oversight. Specific areas of responsibilities may include, strategic planning, adopting and ensuring enforcement of public health regulations, ensuring that the governing body and health department act ethically, serving as a strong link between the health department and the community and other community organizations, supporting a culture of quality improvement, hiring and evaluating the health department director, exercising taxing authority, and adopting budgets. In addition to governing entities that have a formal role in decision-making, health departments may also have advisory boards that play an important role in assisting the health department or policy makers in decisions that affect overall health department operations or public health in the jurisdiction. Making sure that governing entities and advisory boards are well-versed in public health, the work of the health department, and the health challenges of the community will enable them to more effectively support decision making to promote the public's health. The health department should communicate regularly with its governing entities and advisory boards on the health of the community, strategic plan implementation, program activities, health department policy issues, public health ethical issues, quality improvement activities, and strategies for the health department to manage uncertain and unplanned events (pandemics, outbreaks, natural disasters, or other events). See the section on Governance in the introduction of **The Standards**.

MEASURE 10.3.1 A:

Deliberate and resolve ethical issues.

Purpose & Significance

The purpose of this measure is to assess the health department's process for the resolution of ethical issues that arise from the health department's programs, policies, interventions, and employee/employer relations. Efforts to achieve the goal of protecting and promoting the public's health have inherent ethical challenges. Understanding the ethical dimensions of policies and decisions is important for the provision of effective public health services and public health management. Defining and addressing ethical issues should be handled through an explicit, rigorous, and standard manner that uses critical reasoning.

MEASURE 10.3.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 process	**Dated Within** 5 years
1. A process describing how ethical issues are deliberated **and** resolved. The process must describe:			
a. Which individuals are responsible for making collaborative decisions about ethical issues.	**For required element a:** Having multiple individuals involved in the decision-making process allows diverse perspectives and expertise to deliberate about the ethical issue. To foster accountability, health departments may wish to be transparent about who participates in this decision-making process. The process could include, for example, how the decision-making panel for a given ethical issue is appointed (e.g., who makes the appointment, what factors are considered when appointing a panel for a particular issue, or who is responsible for determining when issues rise to the level of requiring an ethical review or how issues are identified) or what standing committee serves as an ethics panel (e.g., if the health department has designated an ethics board, or an existing committee—governing entity, executive leadership team, community council—to be responsible for the resolution of ethical issues).		
b. How the decisionmakers gather information, including input from affected stakeholders.	**For required element b:** The process will describe the general process that will be used to gather information to aid in decision making. This will include, at minimum, gathering input from those who will be affected by the decision (e.g., to understand how they will be affected in the short and long-term, and to learn about their interests, perspectives, and concerns). It could also include how the decision makers will, for example, gather additional facts or relevant research (e.g., to understand the public health consequences of potential resolutions), learn about how other jurisdictions have addressed similar issues, or determine if there is any precedent within the jurisdiction.		
c. How the decision could be re-evaluated in light of new information.	**For required element c:** Because ethical decisions are often made in the context of evolving situations (e.g., as additional research findings about diseases become available or as conditions in the environment change), it is important that the process have a provision for revisiting decisions based on new information. The process will describe the process for reconsidering and—if possible and appropriate—reversing the decision. This could include, for example, an opportunity for stakeholders to "appeal" a decision or a scheduled time for the decision makers to review decisions based on new evidence.		
d. How the decision is communicated back to affected stakeholders.	**For required element d:** To build community trust, it is important that the health department communicate with affected stakeholders about decisions that are made. The process could include, for example, timelines for when stakeholders are informed (e.g., within two weeks of a hearing) or modes of communication (e.g., by posting the decision on the website or corresponding in writing with the affected stakeholders).		

MEASURE 10.3.1 A: Required Documentation 2	Guidance	Number of Examples 1 example	Dated Within 5 years
2. Resolution or prevention of the occurrence of an ethical issue using the process provided in Required Documentation 1. If an ethical issue has not occurred within the timeframe or since the deliberative process was adopted by the health department, an exercise using the deliberative process from Required Documentation 1 must be submitted as documentation for this requirement.	The example could demonstrate deliberation of ethical issues related to public health or general management ethical issues. Alternatively, the health department could demonstrate how it implemented the process from Required Documentation 1 to prevent the occurrence of an ethical issue from occurring; for example, considering the potential ethical implications or dilemmas faced related to vaccine roll-out and using a deliberative, collaborative process that includes input from stakeholders and the best available evidence to set the policy for how to conduct that roll-out. Public health ethical considerations may require balancing restriction of individual freedoms or autonomy to protect the public good. For example, as part of communicable disease control (e.g., isolation and quarantine orders) there may be ethical considerations related to balancing an individual's confidentiality protections while informing those who might have been exposed to an infectious condition (e.g., contact tracing). Ethical issues might also relate to delivery of service considerations, for example, prioritizing populations in the allocation of scare resources (e.g., vaccination or testing strategies). Other examples could address, for example, weighing the benefits and costs of changes to the public water supply or sewage system (e.g., shifting from privately constructed to public sewage systems). General ethical issues could include, for example, the acceptance of gifts policies among employees, particularly those serving in a regulatory capacity (e.g., food establishment inspectors offered free meals or beverages during inspections), unauthorized use of social media, or balancing employee rights to express political or advocacy freedom within the workplace. **Documentation Examples** Documentation could include, for example, meeting minutes from an ethics committee or a report of the consideration and decision made pertaining to an ethical issue.		

MEASURE 10.3.2 A:

Orient the governing entity and advisory board.

Purpose & Significance

The purpose of this measure is to inform governance of its responsibilities, the responsibilities of the health department, and health status of the community. Governing entities significantly influence the direction of health departments through policy making and other activities. Many governing entities have key roles in resource allocation, policy making, legal authority, collaboration, and quality improvement activities. To be an effective advocate for public health and for the agency, the governing entity will be aware of its responsibilities and duties, the health department's roles and responsibilities, and the health status of the community. If the health department also has advisory boards that are mandated by state, local, or Tribal law or regulation, those entities should also receive orientation so they can support public health decision making.

MEASURE 10.3.2 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example per governing entity or advisory board	**Dated Within** 5 years
1. Orientation of new members of the governing entity(ies) **and** advisory board(s). New member orientation must include:	The intent of this requirement is to demonstrate the process that was used to orient new governance members, which includes the responsibilities of the health department and the governing or advisory entity. The health department could have multiple governing entities (e.g., city council, county commissioners) or entities that serve in an advisory role. For example, a health department's governing entity may be the board of health, but approval of ordinances or budgetary items may fall under the authority of a city council, county commissioners, or district advisory committee. In these instances, the health department will show examples of orienting each of these entities. The content of the orientation may differ based on their role and associated responsibilities. If others provide orientation, the health department may demonstrate how it supplemented or worked with the other entity that provides orientation to ensure the materials address required elements a-c.		
a. The responsibilities of the health department, including major programs **and** public health authorities.	**For required element a:** The description of the responsibilities will include major program areas (e.g., maternal and child health, chronic disease) and authorities (e.g., enforcement authority, authority or issue quarantine orders). The description could also include, for example, population health initiatives or an explanation of how the health department fulfills the 10 Essential Public Health Services or the Foundational Public Health Services.		
b. The public health responsibilities of the governing entity or advisory group.	**For required element b:** The responsibilities will relate to the authorities for the governing entity that is receiving the orientation. For example, some entities have the authority to issue a public health order, while others serve in an advisory capacity.		
c. The health status of the community **and** priority issues. If the health department has multiple governing entities or mandated advisory boards, it must provide an example for **each** governing entity. If no new governance members have been appointed/ elected in the last 5 years, the documentation must show an implementation of the orientation process with governance as a refresher.	**For required element c:** The orientation could include, for example, sharing the state/Tribal/community health assessment findings and priorities identified in the state/Tribal/community health improvement plan. The health department may also share information about health inequities and their root causes. **Documentation Examples** Documentation could include, for example, meeting minutes, PowerPoint presentation, or orientation materials. The Documentation Form could indicate to whom the orientation was delivered.		

MEASURE 10.3.3 A:

FOUNDATIONAL CAPABILITY MEASURE

Communicate with governance routinely and on an as-needed basis.

Purpose & Significance

The purpose of this measure is to assess transparency between the health department and governing entity(ies) and advisory boards through ongoing and open dialogue about current and emerging issues facing the health department, public health practice, and the health of the community. Transparent, accountable, and inclusive governance requires flow of information to ensure the governing entity(ies) and advisory boards are informed about context, policies, and practices that impact the health department and health of the community. Sharing with staff about the discussions with the governance helps to build a strong relationship between the governing entity and the health department as a whole.

MEASURE 10.3.3 A: Required Documentation 1	Guidance	Number of Examples: 1 process description per governing entity or advisory board	Dated Within: Current
1. Method(s) **and** frequency of regular communication with its governing entity(ies) **and** mandated advisory board(s). If the health department has multiple governing entities or mandated advisory boards, it must provide the process for each one.	Methods could include, for example, regularly scheduled meetings, scheduled correspondence (e.g., board packets sent on regular intervals), newsletters specific to the governing entity, or other scheduled written materials (e.g., annual report or quarterly performance management reports). Frequency could be described, for example, within the governing entity's charter or bylaws, legal requirements (e.g., ordinances may dictate the frequency of communication), orientation materials, or a memo. If appropriate, the documentation could be supplemented with a description in the Documentation Form about additional forms of regular communication. The health department may have multiple governing entities (e.g., city council, county commissioners) or entities that serve in an advisory role. For example, a health department's governing entity may be the board of health, but approval of ordinances or budgetary items may fall under the authority of a city council, county commissioners, or district advisory committee. In these instances, the health department will describe methods and the frequency of communicating with each of these entities.		

MEASURE 10.3.3 A: Required Documentation 2	Guidance	Number of Examples: 1 example	Dated Within: 2 years
2. Communication about an emergent issue with the health department's governing entity or advisory board outside of its regular communications.	The intent of this requirement is that communication with governance be transparent and flexible enough to expand beyond the established frequency or traditional methods if needed. Communications could include, for example, informing the governing entity about legislative or policy changes and their implications on public health practice or the health department, sharing information in rapid form during an emergency or emerging issue (e.g., changes in the availability of community resources or population health issues), or communicating for rapid decision making (e.g., key personnel or budget decisions). The communications could be initiated by either the health department or the governing entity. If the health department has multiple governing entities or entities serving in an advisory capacity, the health department may select and provide documentation for this requirement based on any one of those entities.		

MEASURE 10.3.3 A: **Required Documentation 3**	**Guidance**	**Number of Examples** 2 examples	**Dated Within** 2 years
3. Sharing information discussed by the governing entity or advisory board with all levels of health department staff.	The intent of this requirement is to foster awareness among staff at all levels of the health department about priorities, policy positions, opinions, or actions of the governing entity. Information flow about the governing entity's discussions facilitates knowledge among staff of the important issues facing the health department and public health practice, as well as its future. Staff at all levels will depend on the health department's organizational structure, generally consisting of frontline, mid-level, and leadership (managerial or supervisory) staff. If the health department has multiple governing entities or entities serving in an advisory capacity, the health department may select and provide documentation for this requirement based on any one of those entities. **Documentation Examples** Documentation could include, for example, minutes from an all-staff meeting that included as an agenda item a summary of governing entity discussion; an email sent to staff describing governing entity discussions; or a notification to all staff about where they can find minutes from governing entity meetings on an intranet or website.		

MEASURE 10.3.4 A:

FOUNDATIONAL CAPABILITY MEASURE

Access and use legal services in planning, implementing, and enforcing public health initiatives.

Purpose & Significance

The purpose of this measure is to demonstrate the health department consults or engages with its legal counsel to advance public health law through legal review of policies and laws, and supports the health department to mitigate risk, conduct negotiations, and ensure legal compliance. Access to legal counsel protects the health department from liability and harm by providing advice to mitigate administrative or operational risks. In addition, access to legal counsel provides opportunities for collaboration to advance public health law or legal epidemiology (i.e., the study of how laws affect population health).

MEASURE 10.3.4 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 example	**Dated Within** 5 years
1. Engagement with legal counsel. If the health department has not consulted with legal counsel in the past 5 years, it must provide a description of the current process for requesting legal counsel.	The intent of this requirement is for the health department to demonstrate how it has consulted or otherwise engaged legal counsel. Engagement with legal counsel could be demonstrated, for example, through the review of current or proposed laws or policies either for their implications to the health department or public health practice. More advanced methods of legislative review of policies or laws could consider more formal approaches to public health legal epidemiology by systematically reviewing laws or policies to understand the features of the laws. Other examples could demonstrate consulting with the health department's legal counsel for review or advice on agreements with external parties (e.g., contracts or MOUs/MAAs) or negotiations. **Documentation Examples** Documentation could include, for example, the health department's request for advice, legal opinion, or drafting of legislation or policies; or in the review of formal agreements (MOUs/MAAs, contracts), negotiations, or trainings materials.		

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1600 Duke Street
Suite 450
Alexandria, VA 22314
(703) 778.4549

phaboard.org