

# Standards & Measures for **Reaccreditation**

Version 2022



*Adopted February 2022*





Standards  
& Measures for  
**Reaccreditation**  
Version 2022

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## INTRODUCTION

This Public Health Accreditation Board (PHAB) **Standards & Measures for Reaccreditation, Version 2022** document serves as the official standards, measures, required documentation, and guidance blueprint for PHAB national public health department continued 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 using Standards & Measures for Reaccreditation, Version 2022.

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. Throughout this document, references to “accreditation” are inclusive of reaccreditation, which is the process of maintaining accreditation status.

**The Standards** provide requirements and guidance for public health departments preparing for reaccreditation 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 reaccreditation. 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.

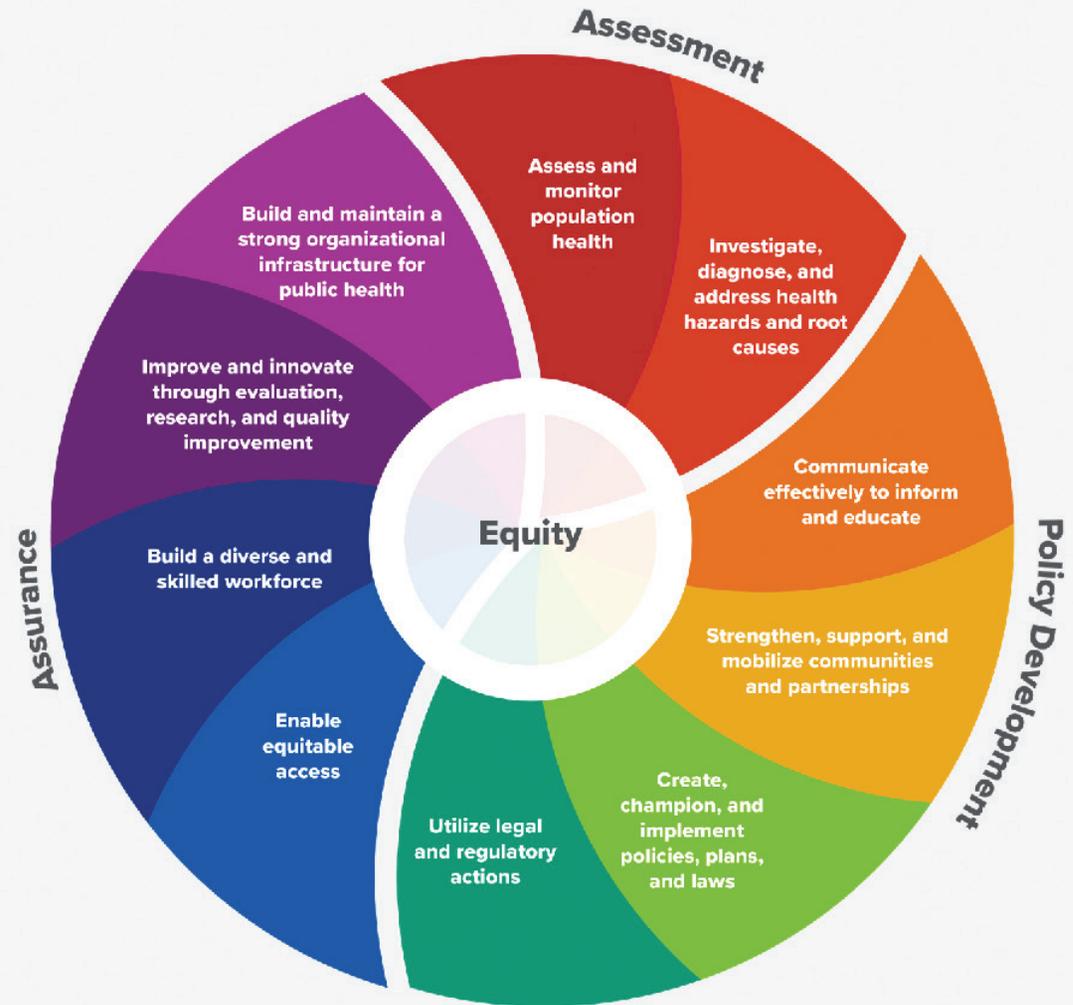
**All of the standards are the same for Tribal, state, and local health departments.** The majority of the measures are the same for Tribal, state, and local health departments and these are designated with an “A” for “all.” Where the measure is specific to Tribal, state, or local health departments, 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:

<b>Domain</b>	Example – Domain 1
<b>Standard</b>	Example – Standard 1.2
<b>Measure</b>	Example – Measure 1.2.2
<b>Tribal, State, Local or ALL</b>	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 control, 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**



# STRUCTURE OF THE REQUIREMENTS

## 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.

<p><b>MEASURE 1.1.1 A:</b> <b>Required Documentation #</b></p>	<p><b>Guidance</b></p>	<p><b>Number of Examples</b> 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.</p>	<p><b>Dated Within</b> This section states the time frame for the date on the documentation. The date the health department submits its initial set of documentation to PHAB is the date that will be used to assess if the documentation meets the timeframe requirement.</p>
<p>This section lists the documentation that the health department must provide as evidence that it is in conformity with the measure. All elements <b>must</b> be included to fully demonstrate the measure.</p> <p>The documentation will be numbered:</p> <ol style="list-style-type: none"> <li>1. Xxx</li> <li>2. Xxx             <ol style="list-style-type: none"> <li>a) xxx</li> <li>b) xxx</li> </ol> </li> </ol>	<p>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 <b>not</b> need to submit documentation that aligns with these examples.</p>		

# REQUIREMENTS FOR ALL DOCUMENTATION

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.

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). Narratives of examples must also include a date so the Site Visit Team will know if the example occurred during the required timeframe.
- Narrative descriptions must describe the health department’s current processes, procedures, or activities in place at the time of documentation submission.
- Documentation, including narrative descriptions, that require evidence “since the last round of accreditation” refer to the most recent accreditation cycle completed by the health department (whether that was initial accreditation or a previous cycle of reaccreditation).
- If the “Number of Examples” column calls for anything other than an “example” or “narrative of 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, including narratives, 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](http://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 that a narrative description is required. In these cases, the health department will use the Documentation Form by typing a narrative in the designated space on the form. All required documentation

elements must be clearly identified within the narrative (e.g., the narrative related to required element b will be easily identifiable by the Site Visit Team).

Some measures in **The Standards** indicate an example or process is required **and** also indicate a narrative is acceptable. In these cases, the health department will either provide the narrative in the space provided on the Documentation Form or reference the PDF page number of the relevant part of documentation provided. For these requirements, when **The Standards** indicate either a narrative or other documentation may be provided, a health department may provide a combination of both documentation and narrative description, so long as all required elements are clearly included and are easily identifiable by the Site Visit Team.

If the “Number of Examples” column **does not say** that a narrative description or a narrative of an example is acceptable, then the health department must provide documentation (e.g., a policy, plan, press release, report, or other document). It is possible that some elements of the documentation could be described in the Documentation Form. In those instances, the “Required Documentation” column will indicate when a specific required element(s) may be provided on the Documentation Form in lieu of documentation. 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.

In addition, as part of the reaccreditation process, the health department will describe for at least three measures their plans for Continued Advancement, using the Accreditation Forms available from PHAB for this purpose. Health departments will be asked about their progress on these measures as part of the Annual Reporting process.

## 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. Similarly, narrative descriptions and narratives of examples will include the date of the example(s).

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.

Narrative descriptions describe what is current and in place at the health department at the time of documentation submission. Narrative descriptions prepared in advance of a health department’s documentation submission date should be reviewed within 1 year of submission in order to ensure a good faith effort to confirm the information provided is current.

Some measures in **The Standards** reference “the last round of accreditation.” This statement refers to the most recent accreditation cycle completed by the health department.

## 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. Narrative

Descriptions and Narratives of Examples will also include evidence of authenticity by describing the health department's role in the activity as well as how other entities were engaged, as appropriate.

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 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.

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](http://www.phaboard.org)).

## 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 following table shows principles about what PHAB's accreditation **does not** cover.

<p><b>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.</b></p>	<p>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.</p> <p>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).</p>
<p><b>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.</b></p>	<p>These programs have oversight from either the Centers for Medicare &amp; 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.</p>
<p><b>3. Individual professional and facilities licensure and certificate programs are outside the scope of PHAB accreditation.</b></p>	<p>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.</p>
<p><b>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.</b></p>	<p>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.</p>

## 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](http://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

<b>Standard 1.1:</b>	Participate in or lead a collaborative process resulting in a comprehensive community health assessment.
<b>Standard 1.2:</b>	Collect and share data that provide information on conditions of public health importance and on the health status of the population.
<b>Standard 1.3:</b>	Analyze public health data, share findings, and use results to improve population health.

### FOUNDATIONAL CAPABILITY MEASURES:

<b>Assessment &amp; Surveillance</b>	<b>1.1.1 A:</b>	Develop a community health assessment.
	<b>1.2.1 A:</b>	Collect non-surveillance public health data.
	<b>1.2.2 T/L:</b>	Participate in data sharing with other entities.
	<b>1.2.2 S:</b>	Engage in data sharing and data exchange with other entities.
	<b>1.3.1 A:</b>	Analyze data and draw public health conclusions.

## STANDARD 1.1

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

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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. CHAs 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 community health assessment 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 CHA and are provided with key findings from the assessment in a manner they understand.

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 community health assessment 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, the 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 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 state, Tribal, or local level 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.

<b>MEASURE 1.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>1. Community health assessment (CHA) that must include <b>all</b> of the following elements:</p>	<p>This may be referred to as a state health assessment, Tribal health assessment, health needs assessment, or other name.</p> <p>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.</p> <p>The collaborative partnership may determine that the community health assessment be updated on a different schedule, such as every 3 years.</p> <p>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.</p> <p>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. <b><u>It is not necessary for the process description to be within the health assessment document itself.</u></b></p>		

<b>MEASURE 1.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>a. A list of participating partners involved in the CHA process. Participation must include:</p> <ul style="list-style-type: none"> <li>i. At least 2 organizations representing sectors other than governmental public health.</li> <li>ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.</li> </ul>	<p>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).</p> <p><b>For required element a:</b> 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.</p> <p>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.)</p>		

<b>MEASURE 1.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>b. The process for how partners collaborated in developing the CHA.</p>	<p>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.</p> <p>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.</p> <p><b>For required element b:</b></p> <p>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.</p> <p>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.</p>		

<b>MEASURE 1.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>c. Comprehensive, broad-based data. Data must include:</p> <ul style="list-style-type: none"> <li>i. Primary data.</li> <li>ii. Secondary data from two or more different sources.</li> </ul>	<p>Required elements c-g are the data and information that comprise the assessment itself.</p> <p><b>For required element c:</b> 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.</p> <p>Secondary data sources might include federal, Tribal, state, 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.</p> <p>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.</p>		

<b>MEASURE 1.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>d. A description of the demographics of the population served by the health department, which must, at minimum, include:</p> <ul style="list-style-type: none"> <li>i. The percent of the population by race and ethnicity.</li> <li>ii. Languages spoken within the jurisdiction.</li> <li>iii. Other demographic characteristics, as appropriate for the jurisdiction.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>i. Health status.</li> <li>ii. Health behaviors.</li> </ul>	<p><b>For required element d:</b> 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.</p> <p><b>For required element e:</b> 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.</p> <p>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.</p>		

<b>MEASURE 1.1.1 A:</b> <b>Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 community health assessment	<b>Dated Within</b> 5 years
<p>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.</p> <p>g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges.</p> <p>The CHA must address the jurisdiction as described in the description of Standard 1.1.</p>	<p><b>For required element f:</b>            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.</p> <p>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 <b>may</b> 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.</p> <p><b>For required element g:</b>            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 <b>not</b> 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. Intangible 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).</p>		

**MEASURE 1.1.2 A:**

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## Collaborate on and use the community health assessment process.

**Purpose & Significance**

The purpose of this measure is to assess both how the community health assessment partnership has evolved to deepen its focus on diversity, equity, and inclusion; and how the community health assessment has been used to support efforts to improve population health. The partnership engaged in the assessment process will change over time to develop a thorough understanding of the health needs and assets throughout the jurisdiction. The CHA is a resource for all members of the public health system and the population at-large. It serves as a foundation for collaboration, priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets and resources to improve population health.

MEASURE 1.1.2 A: Required Documentation 1	Guidance	Number of Examples Narrative description	Dated Within 5 years
<p>I. Evolution of the community health assessment partnership's membership with a diversity, equity, inclusion lens.</p>	<p>The intent of this requirement is to describe how participation in the state/Tribal/community health assessment partnership has evolved since the previous accreditation cycle in a way that, for example, intentionally seeks to be inclusive of diverse perspectives and stakeholders from groups that have been historically excluded or marginalized, considers how power dynamics are addressed in a manner that shifts power to community voices, considers how members of the partnership can better understand inequities in the community, or partners with community members and people with various lived experiences and expertise. This could include, for example, adding new or different members to provide additional perspectives or working to retain or more actively engage members. Health departments can consider a range of approaches in their efforts to intentionally elevate the voices of those that have been traditionally disenfranchised, such as the use of frameworks or models (e.g., Ladder of Participation) or using power mapping as they consider who is included in the CHA partnership.</p> <p>New members can provide additional data sources, information, resources, and different perspectives to the community health assessment. Potential partnerships may be shaped based on health disparity data. For example, if the data show disparate outcomes among individuals with disabilities, the CHA partnership may wish to obtain representation from community leaders or local or regional aging or disability agencies, or to engage an Inclusive Health Coalition (composed of community members, self-advocates, families, community or faith leaders, and health care providers with disability health expertise).</p> <p>It is <b>not</b> necessary to increase the total number of members. The narrative could describe efforts to change the composition of the partnership to better represent or learn about the community. Additional sectors could include, for example, local or state government (e.g., elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, school boards, family and child services, or homeless services); businesses and industries; chambers of commerce; or academic institutions.</p> <p>Efforts to increase inclusiveness could help the partnership retain or more actively engage existing members or could potentially encourage participation from new and more diverse members. Efforts could include, for example, providing stipends, addressing barriers to participation (i.e., lack of childcare), or meeting in locations that are more accessible to community members.</p> <p>In smaller or rural communities, efforts might entail adding only one new partner (e.g., community-based organization or community college) or expanding the reach to include county, regional, or state partners. Regional partnerships may help rural jurisdictions with sparse populations to tackle common issues, such as gaining a better understanding of inequities and strategies to address them.</p>		

<b>MEASURE 1.1.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Use of the community health assessment by either the health department or partner(s).</p> <p>The example must go beyond how the health assessment was used in the development of the health improvement plan.</p>	<p>The state/Tribal/community health assessment provides a foundation for efforts to improve the health of the population. In addition to being the basis for development of the health improvement plan, it could be used, for example, as a basis for setting priorities, planning, program development, funding applications, policy changes, and coordination of community resources and collaborative use of assets.</p> <p>While the example could include how the assessment was used in developing the health improvement plan, it will also include a specific use beyond planning purposes. For example, the example could show how using the assessment data, as part of the planning process, also led the health department to pursue a funding opportunity with its planning partners.</p>		

## **STANDARD 1.2**

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

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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 collection of primary data to create an increasingly robust, accurate, and useful understanding of community health status. This could build on the community health assessment, as the community partnership continually increases its understanding of health issues and resources by asking additional questions and gathering additional data. The health department might also collect new data because of changing priorities in the community or to gather more information to better understand secondary data.

<b>MEASURE 1.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example of quantitative data collection <b>and</b> 1 example of qualitative data collection	<b>Dated Within</b> 1 example dated within 2 years; the other within 5 years
<p>1. Primary population health data collected for the purpose of further understanding health status in the jurisdiction, including:</p>	<p>Primary population health data provide the health department with information about health status, health disparities, or contributing factors or causes of health challenges. Data could be specific to a particular neighborhood, population, health issue, age group, or program area, for example. The collection of data does <b>not</b> need to be jurisdiction-wide.</p> <p>The intent of this requirement is to demonstrate the health department's capacity to collect primary data which forms a deeper understanding of health status in the community. Collection of more routine primary data collected for the purposes of surveillance, program evaluation, or customer satisfaction would <b>not</b> meet the intent of this requirement. Documentation could include, for example, data collected, reports, presentations, summaries of findings, or excerpts from the state/Tribal/community health assessment.</p> <p>In addition to the data or summary of data collected, each example will also include a description of why the health department collected the data to further their understanding of health in the jurisdiction. A description could discuss, for example, further exploration of an issue initially identified in the state/Tribal/community health assessment to better understand the reasons or causes of disparities within a neighborhood that experiences poorer health outcomes, or gathering additional population health data related to a strategic plan objective. This description could be included within the documentation or could be provided within the Documentation Form.</p> <p>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 Centers), 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. If the health department's role in data collection is not evident, it could be clarified in the Documentation Form.</p>		

<b>MEASURE 1.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example of quantitative data collection <b>and</b> 1 example of qualitative data collection	<b>Dated Within</b> 1 example dated within 2 years; the other within 5 years
<p>a. One example of the health department's collection of primary quantitative data <b>and</b> why the data were collected.</p> <p>b. One example of the health department's collection of primary qualitative data <b>and</b> why the data were collected.</p> <p>The collected data must provide information about the health status of the population or the factors contributing to the health status.</p> <p>The health department can provide either the data collected or a summary of the data.</p>	<p>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 can be used for both required element a and required element b. If using the same instrument, the Documentation Form will indicate where the quantitative and qualitative questions are located in the instrument.</p> <p><b>For required element a:</b>            Primary quantitative data could be collected through, for example, close-ended surveys of priority groups (e.g., teenagers, jobless individuals, residents of a neighborhood with higher risks of poor health outcomes).</p> <p>Vital statistics or Behavioral Risk Factor Surveillance System (BRFSS) data could be provided if they are primary data for the health department.</p> <p><b>For required element b:</b>            Qualitative data could be from, for example, key informant or group interviews, open-ended survey questions, asset mapping, storytelling, focus groups, community or town forums, listening groups, or other culturally appropriate methods, such as talking circles or Tribal consultation. The topics addressed in qualitative data could include, for example, the population's perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Primary data may be limited to a particular issue, population, or geographic area.</p> <p>Non-traditional and non-narrative data are acceptable, including, for example, 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, or use of empathy mapping or ethnographic interviews to gather an understanding of current and historical inequities and their impact.</p>		

**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.

<b>MEASURE 1.2.2 T/L:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 2 years
<p>1. Participation in data sharing with other entities, by either:</p> <ul style="list-style-type: none"> <li>a. Providing data to another entity; <b>or</b></li> <li>b. Receiving data from another entity; <b>or</b></li> <li>c. Providing a data use agreement with another entity.</li> </ul> <p>The data being shared must include record-level data.</p>	<p>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 <b>not</b> 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.</p> <p>The entity could be, for example, an organization, an individual, another local or Tribal health department, or the state health department.</p> <p>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 health 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.</p> <p>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.</p> <p>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.</p> <p><b>Documentation Examples</b>            Documentation could be, for example, emails, screen shots documenting data were shared or received through web pages or a portal, or data use agreements.</p>		

**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.

<b>MEASURE 1.2.2 S: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 process</b>	<b>Dated Within 5 years</b>
<p>1. A data use process that includes:</p> <p>a. A description of how the health department makes data and supporting materials available to others upon request.</p> <p>b. A description of the steps the health department takes to maintain confidentiality as appropriate.</p> <p>c. The process used to ensure requests receive responses.</p> <p>The process must describe sharing record-level data.</p> <p>This process must pertain to data requests from both other health departments and from other individuals or organizations.</p>	<p>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 <b>not</b> 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.</p> <p>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.</p> <p><b>For required element a:</b> 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 <b>not</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> The process to ensure the requests are resolved might address how a tracking log or other process is maintained and used.</p>		

<b>MEASURE 1.2.2 S: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 list	<b>Dated Within</b> 5 years
<p>2. List of data standards used for data exchange.</p> <p>The standards must be developed and maintained by national or international standards development organizations.</p> <p>The list could be provided in the Documentation Form.</p>	<p>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.</p> <p>Standards used to codify, package, and transport data that are developed and maintained by national or international standards development organizations include, for example:</p> <ul style="list-style-type: none"> <li>• Vocabulary/Terminology standards (e.g., Logical Observation Identifiers, Names and Codes (LOINC), Systematized Nomenclature of Medicine–Clinical Terms (SNOMED–CT), and RxNorm)</li> <li>• Content standards (e.g., Health Level Seven (HL7))</li> <li>• Transport standards (e.g., Fast Healthcare Interoperability Resources (FHIR®) and Direct Standard™)</li> </ul>		
<b>MEASURE 1.2.2 S: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 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)	<b>Dated Within</b> 5 years
<p>3. Capacity to exchange data electronically with each of the following:</p> <p>a. Federal government.</p> <p>b. Other state, local, or Tribal health departments.</p>	<p>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 <b>not</b> 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).</p> <p>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.</p> <p><b>For required element a:</b> Federal agencies could include, for example, the CDC, CMS, or USDA.</p> <p><b>For required element b:</b> The health department could demonstrate data exchange with other state health departments or with local or Tribal health departments.</p>		

<b>MEASURE 1.2.2 S: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 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)	<b>Dated Within</b> 5 years
<p>c. Other entities.</p> <p>At least one of the examples must include bidirectional data exchange.</p>	<p><b>For required element c:</b> Other entities could include, for example, health care providers, or laboratories.</p>		

## MEASURE 1.2.3 S:

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Provide assistance to local and Tribal health departments regarding statewide data systems, data collection, and use.

### **Purpose & Significance**

The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in using statewide data systems and in other aspects of data collection and use. 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 department should have mechanisms through which Tribal and local health departments can access data generated through those systems. In addition, state health departments may be in a position to provide additional support to Tribal and local health departments to help bolster their capacity to collect and use data.

<b>MEASURE 1.2.3 S: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples Narrative description</b>	<b>Dated Within Current process(es)</b>
<p>1. The process for helping <b>both</b> local and Tribal health departments to collect and use data, which must include:</p> <p>a. How the state health department identifies what support local and Tribal health departments need to productively participate in statewide data systems.</p> <p>b. How the state health department is responsive to those needs.</p> <p>c. How local and Tribal health departments are able to access reports from statewide data systems.</p>	<p>State health departments play a critical role in ensuring Tribal and local health departments understand, have access to, and use data, including statewide data systems.</p> <p>The state health department <b>cannot</b> describe providing support to program divisions within the state health department's central office. In a centralized state, the description will focus on providing support to staff serving local jurisdictions and to Tribal health departments.</p> <p><b>For required element a:</b> This would include efforts for the state, for example, to get feedback from local and Tribal health departments about technical assistance needs; to gather suggestions on system modifications that would make the system more usable; to engage local and Tribal health departments in the development of new systems to ensure their feedback is reflected in requirements; to review requests or questions that the state health department received from local or Tribal health departments; or to review 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 systems).</p> <p><b>For required element b:</b> The health department could demonstrate it is being responsive to needs by describing how it provides technical assistance or support (e.g., support using or uploading data into statewide data sharing systems) that aligns with requests from required element a. 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.</p> <p><b>For required element c:</b> This could include, for example, how local and Tribal health departments are able to make requests for data or generate reports directly from the system. The intent is that Tribal and local health departments be able to access report(s) specific to their jurisdiction (or data about a subset of their population, for example, residents living in a zip code). The reports could also allow for comparisons across health departments.</p>		

<b>MEASURE 1.2.3 S: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current process(es)
<p>d. How the state health department provides additional support related to data collection, sharing, or use.</p> <p>If there is not a Tribal health department in the state, this must be indicated in the Documentation Form.</p>	<p><b>For required element d:</b> The process will describe the state health department's support related to improving other aspects data collection, sharing, or use. For example, it could include technical assistance for administering surveys or focus groups, best practices in data sharing, access to analytical tools and training, or support related to making data available to the public. The support might also relate to use of data visualization tools, infographics, and dashboards, which can be powerful in benchmarking progress and facilitating communications with the public, private sectors, policy makers, and funders.</p>		

## STANDARD 1.3

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

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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, as well as its ability to draw conclusions and to engage with others about data findings. Analysis of data is important for assessing the contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions of a health problem. Drawing conclusions from data is critical for problem identification, program design, and evaluation of programs for continuous quality improvement. 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.

<b>MEASURE 1.3.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 2 examples</b>	<b>Dated Within 5 years</b>
<p>1. Data from multiple sources analyzed with findings shared. Each example must include:</p> <p>a. At least some data specific to the population served by the health department. One example must include data about a subset of the jurisdiction's population.</p> <p>b. At least two data sources per example. At least one example will include qualitative data.</p> <p>c. The analytic process used. (If the analytic process used is not evident in the example, it could be indicated in the Documentation Form.)</p>	<p>The purpose of this requirement is to assess the health department's capacity for data analysis in order to identify findings to understand health problems, assess behavioral risk factors, detect environmental public health hazards, or recognize social and economic conditions that affect the public's health.</p> <p><b>For required element a:</b> The data could be collected by the health department or not, as long as it includes data specific to the population. In other words, for a Tribal or local health department, analysis of statewide data would <b>not</b> meet the intent of this requirement. The data for one example will be about a subset of the jurisdiction, which could be about a specific neighborhood, community, or subpopulation in order to understand health inequities or health disparities and factors that contribute to populations having higher health risks and poorer health outcomes.</p> <p><b>For required element b:</b> Data used in the analysis may be primary or secondary, but each example will identify at least two sources of data. For example, the analysis could include Census or Bureau of Labor Statistics data about employment rates as well as data from BRFSS about health behaviors.</p> <p><b>For required element c:</b> The analysis could be conducted by others, such as the state health department, an academic institution, or other organizations.</p> <p>Analytic processes for quantitative data could include, 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. Analytic processes for qualitative data could include, for example, content analysis or thematic analysis. The intent of this required 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 <b>not</b> require the use of statistical applications. The analytic process may be indicated in the Documentation Form.</p>		

<b>MEASURE 1.3.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 5 years
<p>d. Conclusions drawn from data analysis.</p> <p>e. Engagement with external stakeholders about findings. One example must include the health department's governing entity or advisory board.</p>	<p><b>For required element d:</b> Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications (e.g., highlighting what will have the biggest impact on the community), drawing inferences about the relationship between different variables (e.g., the relationship between socioeconomic status and health outcomes), or making hypotheses about potential causes of the findings (e.g., hypothesizing a link between poor air quality and school absenteeism in some neighborhoods). The conclusions could be part of a report with the analysis or they could be provided to supplement the analysis report (e.g., if the health department is presenting on an analysis conducted by a university, the presentation could contain the health department's conclusions about the local implications).</p> <p><b>For required element e:</b> The intent of this requirement is for the health department to engage with stakeholders about data. This could include the health department, for example, presenting on data to facilitate their use by others, having discussions about findings with others to gain additional insights on the interpretation of those data, or sending a report or memo with an explanation of their relevance or implications. The findings could include a summary of the data analysis or the conclusions or both.</p> <p>In addition to engagement 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 <b>not</b> meet the intent of this requirement.</p> <p><b>Documentation Examples</b> Documentation could include, for example, presentations, minutes of briefings, or other communication of the conclusions from data analysis.</p> <p>Evidence of the analysis and conclusions is required for this measure, but the actual data set(s) used in the analysis do <b>not</b> need to be provided.</p>		

**MEASURE 1.3.2 A:**

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# 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.

<b>MEASURE 1.3.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>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.</p> <p>Documentation must identify both the data findings used and the resulting policy, process, program, or intervention.</p>	<p>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 <b>not</b> meet the intent of the requirement.</p> <p><b>Documentation Examples</b> 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.</p> <p>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.</p>		

## 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

<b>Standard 2.1:</b>	Anticipate, prevent, and mitigate health threats through surveillance and investigation of health problems and environmental hazards.
<b>Standard 2.2:</b>	Prepare for and respond to emergencies.

### FOUNDATIONAL CAPABILITY MEASURES:

<b>Assessment &amp; Surveillance</b>	<b>2.1.1 A:</b>	Maintain and improve surveillance systems.
	<b>2.1.2 A:</b>	Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental hazards.
<b>Communications</b>	<b>2.2.5 A:</b>	Maintain a risk communication plan and a process for urgent 24/7 communications with response partners.
<b>Emergency Preparedness &amp; Response</b>	<b>2.2.1 A:</b>	Maintain a public health emergency operations plan (EOP).
	<b>2.2.2 A:</b>	Ensure continuity of operations during response.
	<b>2.2.7 A:</b>	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.

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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 and improve surveillance systems.

**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.

<b>MEASURE 2.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe current system
<p>1. Use of surveillance system(s), which must address:</p> <p>a. The process to maintain the list of surveillance sites.</p>	<p>The intent of this requirement is to assess processes that 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 <b>not</b> meet the intent of this requirement. If vital records data are collected by the health department as part of the surveillance system, vital records could be included in the description.</p> <p>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.</p> <p>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), notifiable disease reporting system, or chronic disease surveillance system. 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.</p> <p>If the health department operates multiple surveillance systems, the narrative description does <b>not</b> need to cover how required elements a-d are addressed in each system. Instead, the narrative can describe general processes that are used across surveillance systems or can provide examples from different systems. For example, the health department could describe collaborative relationships (required element b) related to a its chronic disease surveillance and enhancements made (required element d) to its adverse events reporting system.</p> <p><b>For required element a:</b> Regularly updated and verified list(s) of surveillance sites supports surveillance efforts to know who reports conditions for rapid detection and encourages ongoing engagement to support collaboration during investigations. Surveillance sites 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 of current contact information or reporting methods.</p>		

<b>MEASURE 2.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe current system
<p>b. A description of the health department's collaborative working relationship with reporting sites.</p> <p>c. How surveillance system data are used, including:</p> <ul style="list-style-type: none"> <li>i. Analysis of surveillance data to identify patterns or trends.</li> <li>ii. Analysis of data to identify differences in population groups or root causes of disparities.</li> </ul>	<p><b>For required element b:</b> Collaborative work with reporting sites could address, for example, training sites on notifiable/reportable or emerging conditions or on reporting methods (e.g., clarifying what, how, and when to report notifiable or reportable conditions); communications with general surveillance updates or disease/condition-specific requirements; or opportunities for surveillance sites to provide feedback to the health department about ways to improve the data reporting process.</p> <p><b>For required element c:</b> The process for using surveillance data could include, for example, analysis of aggregated surveillance data to identify patterns or trends across the population served by the health department. Data may be disaggregated and further analyzed to identify differences in population groups. For example, data on heart disease could be disaggregated by demographics, geographics, or other socioeconomic factors. Similarly, a health department could, for example, analyze immunization rates among school-aged children to identify subpopulations or groups requiring vaccination. Analysis might also consider analyzing inputs to consider root causes or contributing factors that influence health status. For example, environmental surveillance datasets could be analyzed to consider implications related to climate change or environmental justice. While the narrative description need not list every analysis conducted, the description will provide sufficient detail to describe generally how these data are used.</p>		

<b>MEASURE 2.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe current system
<p>d. Enhancements or significant changes made to the surveillance system. The health department must include how at least one of those changes was informed by data from the surveillance system.</p> <p>If the health department operates multiple surveillance systems, the description can use examples from any system to illustrate required elements a–d. If one or more of required elements a–d is carried out by another agency, the description will indicate how those functions are performed by others.</p>	<p><b>For required element d:</b> The intent is to describe how surveillance systems have been enhanced or key changes made since the health department’s last round of accreditation (either initial or reaccreditation). Enhancements could be related to the surveillance system or the health department’s use of surveillance systems. If the surveillance system is maintained by others and enhancements to the system are not within the health department’s control, examples could include making recommendations to those who do have control on what improvements should be considered or changes in how the health department interacts with surveillance systems. Key changes or enhancements could include, for example, improving processes for surveillance sites to report more rapidly or accurately, expanding the number of surveillance systems used by the health department to include additional sources, improving existing systems (e.g., modernized systems for rapid detection, greater reporting or analysis capabilities, or interoperability with other systems) or significantly changing how staff use surveillance systems (e.g., using surveillance system data for geocoding or monitoring of additional factors, such as, socioeconomic, or social determinants of health). Enhancement efforts may be formal, such as a quality improvement project or may use less formal methods. Regardless of the methodology, the narrative will include at least one example of how data from the surveillance system were used to inform the change.</p>		

**MEASURE 2.1.2 A:**

## FOUNDATIONAL CAPABILITY MEASURE

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

<b>MEASURE 2.1.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 policy or procedure or a set of policies or procedures that cover laboratory, epidemiology, and environmental resources	<b>Dated Within</b> 5 years
<p>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:</p> <p>a. Laboratory.</p> <p>b. Epidemiology.</p> <p>c. Environmental.</p>	<p>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 <b>and</b> 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.</p> <p>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.</p> <p><b>For required element a:</b> 24/7 access to laboratory may not be necessary for the testing of all specimens and may include access to state laboratory or other laboratories for select specimens (e.g., notifiable or reportable conditions). The policy or procedure may contain, for example, provisions outlining access or instructions for submitting specimens after hours.</p> <p><b>For required element b:</b> 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.</p> <p><b>For required element c:</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).</p>		

**MEASURE 2.1.3 A:**

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Improve and collaboratively implement practices for investigation, containment, and mitigation of health problems and environmental hazards.

**Purpose & Significance**

The purpose of this measure is to assess the health department's ability to conduct investigations and contain and mitigate public health problems and environmental health hazards, in collaboration with others. To advance health equity, containment and mitigation strategies require consideration of social determinants of health or health inequities. Coordinating with other organizations may support faster investigations or more effective mitigation. Partnerships may be particularly important when public health issues cross jurisdictional lines. In addition, working with community partners may help build trust and help reach more members in the community.

<b>MEASURE 2.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Updated practices for investigation or containment or mitigation based on lessons learned or surveillance data.</p>	<p>The intent of this requirement is to demonstrate that practices (which could include protocols or policies) are updated to guide future investigation, containment, or mitigation practices. Practices will be updated to reflect what the health department has learned based on, for example, investigations, containment or mitigation events, exercises, surveillance data, or new guidance or evidence.</p> <p>For example, the health department could update assignments of responsibility among staff, steps to conduct investigations, reporting processes, or contact management (contact tracing) protocols. Examples could also address updates to the health department's protocols for working with others, such as when and how other agencies are notified, how communications are coordinated, or how information is shared when conducting investigations or containment or mitigation efforts.</p> <p>Examples could also address clarifying, improving, or expanding, public health authorities.</p>		
<b>MEASURE 2.1.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>2. Investigation or mitigation action implemented collaboratively to address reportable condition, disease outbreak, injury, or environmental health issue.</p> <p>The examples must be from two different events.</p>	<p>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.</p> <p>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, Tribal, local, and 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 <b>not</b> meet the intent of the requirement.</p>		

<b>MEASURE 2.1.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>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.</p>	<p>If there has not been an event within the timeframe, reports of drills or exercises will be provided. The health department is <b>not</b> 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.</p> <p><b>Documentation Examples</b> Documentation could include investigation reports and records, After Action Reports, meeting minutes, presentations, or news articles.</p>		
<b>MEASURE 2.1.3 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>3. Consideration of social determinants of health or health inequities incorporated into containment or mitigation strategy(ies).</p>	<p>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 <b>not</b> 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).</p>		

<b>MEASURE 2.1.3 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
	<p>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).</p> <p>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).</p> <p>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.</p>		

## MEASURE 2.1.4 S:

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# Communicate about and support investigation 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.

<b>MEASURE 2.1.4 S:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>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.</p> <p>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.</p> <p>If there were <b>no</b> investigations led by the state health department during the 5-year time period, that must be indicated to PHAB and <b>no</b> documentation is needed for this requirement.</p>	<p>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 <b>not</b> the intent of this requirement.</p> <p>The state health department <b>cannot</b> 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.</p> <p><b>Documentation Examples</b>            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.</p>		

<b>MEASURE 2.1.4 S:</b> <b>Required</b> <b>Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>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.</p> <p>If there were <b>no</b> 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 <b>no</b> documentation is needed for this requirement.</p>	<p>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.</p> <p>The state health department <b>cannot</b> 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.</p> <p><b>Documentation Examples</b>            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.</p> <p>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 <b>not</b> 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.</p> <p>The state health department may not be able to meet all the needs of Tribal or local 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.</p>		

## STANDARD 2.2

### Prepare for and respond to emergencies.

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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.

<b>MEASURE 2.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 3 years</b>
<p>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:</p> <p>a. A description of the purpose of the plan.</p> <p>b. The description of incident command system, including designation of staff responsibilities.</p> <p>c. The identification of individuals who are at higher risk, which must include those with access and functional needs.</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p><b>For required element a:</b> The purpose of the plan could be, for example, to outline procedures for preparing for, responding to, and recovering from an emergency.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p>		

<b>MEASURE 2.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 3 years</b>
<p>d. At least two processes in place to meet the needs of individuals at higher risk (identified in required element c).</p> <p>e. The lead role agency(ies), as well as the responsibilities of the health department (if any) specific to the following areas:</p> <ul style="list-style-type: none"> <li>i. Medical countermeasures</li> <li>ii. Mass care</li> <li>iii. Mass fatality management</li> <li>iv. Mental/behavioral health</li> <li>v. Non-pharmaceutical interventions, including legal authority to isolate, quarantine, and, as appropriate institute social distancing</li> </ul>	<p>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).</p> <p>The documentation could be, for example, within the EOP, a separate annex, or another attachment such as a jurisdictional risk assessment (JRA).</p> <p><b>For required element d:</b> 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.</p> <p><b>For required element e:</b> 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.</p>		

<b>MEASURE 2.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 3 years</b>
<p>vi. Responder safety and health</p> <p>vii. Volunteer management (Lead role agency(ies) and page numbers, as appropriate, will be indicated on the Documentation Form.)</p> <p>f. The process of declaring a public health emergency.</p> <p>g. Activation of public health emergency operations, including levels of activation based on triggers or circumstances.</p> <p>h. The process for collaborative review and revision of the plan.</p> <p>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.</p>	<p><b>For required element f:</b> 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.</p> <p><b>For required element g:</b> 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.</p> <p><b>For required element h:</b> 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).</p>		

**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.

<b>MEASURE 2.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>1. Continuity of operations plan, which must include:</p> <p>a. Identification of essential public health functions that must be sustained during a continuity event.</p> <p>b. Orders of succession.</p> <p>c. Identification of an alternate location for key health department staff to report, if necessary, or the ability to work virtually.</p>	<p>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.</p> <p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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).</p>		

**MEASURE 2.2.3 A:**

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

**Purpose & Significance**

The purpose of this measure is to assess how the health department has enhanced and improved its surge capacity, as well as expedited 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.

<b>MEASURE 2.2.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> 5 years
1. Improvements made to the health department's surge capacity.	The intent of this requirement is to describe improvements made to enhance the health department's surge capacity since the health department's last round of accreditation (either initial or reaccreditation), rather than a description of existing resources or processes for activation. For example, improvements could include adding new partners or modifying roles outlined in formal agreements (e.g., MOUs, MAAs, contracts) or identifying additional resources (e.g., personnel, equipment, or supplies). Other examples could include improvements to identifying and engaging personnel or volunteers, such as the Medical Reserve Corp (MRC). The health department may have also expanded how personnel will fill roles beyond laboratory, epidemiological, and environmental personnel (e.g., nurses, health educators, disease investigators, communications specialists or PIO support, logistics or information technology support, or administrative personnel). Improvements could also address, for example, how surge personnel will be notified of their roles and responsibilities in a surge when activated.		
<b>MEASURE 2.2.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 process or set of processes	<b>Dated Within</b> 5 years
2. The process(es) for expedited administrative procedures used during a response to an event for <b>all</b> of the following:	<p>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 <b>not</b> meet the intent of the requirement.</p> <p>The process(es) could take several forms, including, for example:</p> <ul style="list-style-type: none"> <li>• A separate formal policy or plan on expediting administrative procedures).</li> <li>• Part of the Continuity of Operations Plan (COOP).</li> <li>• 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.</li> <li>• 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.</li> </ul>		

<b>MEASURE 2.2.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 process or set of processes	<b>Dated Within</b> 5 years
<p>a. Accepting, allocating, or spending funds.</p> <p>b. Managing or hiring the workforce.</p> <p>c. Contracting or procuring mutual aid.</p>	<p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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).</p>		

**MEASURE 2.2.4 A:**

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## 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.

<b>MEASURE 2.2.4 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 training schedule	<b>Dated Within</b> 5 years
<p>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.</p> <p>This must include surge personnel as well as personnel for whom response is part of their normal job responsibilities. Preparedness does <b>not</b> have to be the sole focus of the trainings or exercises but must be an identifiable component of the trainings.</p>	<p>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 <b>The Standards</b>, 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 <b>not</b> required but documentation will reflect that the schedule has been reviewed within the last 5 years.</p> <p>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.</p> <p><b>Documentation Examples</b> 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.</p>		

<b>MEASURE 2.2.4 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example or 1 process	<b>Dated Within</b> 5 years
<p>2. Proactive or just-in-time training for individuals involved in response activities.</p> <p>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.</p>	<p>The intent is <b>not</b> to provide a routine training (as addressed in the training schedule topics from Required Documentation 1), <b>but instead</b> 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.</p> <p>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.</p> <p><b>Documentation Examples</b> 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.</p>		

**MEASURE 2.2.5 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Maintain a risk communication plan and a process for urgent 24/7 communications with response partners.

**Purpose & Significance**

The purpose of this measure is to assess the health department's plans for risk communications with the public, as well as emergency communication protocols, processes, or systems to communicate with partners during a crisis, disaster, outbreak, or other threat to the public's health. The risk communication plan and emergency communication procedures set forth standardized processes to communicate with the public, media, and partners to inform them of the situation and convey what actions should or should not be taken during an emergency.

<b>MEASURE 2.2.5 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>I. A risk communication plan that:</p> <p>a. Describes the process used to develop accurate and timely messages.</p>	<p>The risk communication plan outlines the methods to provide accurate, timely, effective communications during an emergency.</p> <p>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.</p> <p>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.</p> <p><b>For required element a:</b> 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.</p>		

<b>MEASURE 2.2.5 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>b. Describes methods to communicate necessary information to the entire community, including subpopulations who are at higher risk.</p> <p>c. Addresses misconceptions or misinformation.</p> <p>d. Describes the process to expedite approval of messages to the public during an emergency.</p> <p>e. Describes how information will be disseminated in the case of communication technology disruption.</p>	<p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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.</p> <p><b>For required element e:</b> 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.</p>		

<b>MEASURE 2.2.5 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>f. Describes the process for managing and responding to inquiries from the public during an emergency.</p> <p>g. Describes the process to coordinate the communications and development of messages among partners during an emergency.</p> <p>h. Contains a list with media contact information.</p> <p>i. Describes the procedure for keeping the media contact list current and accurate.</p>	<p><b>For required element f:</b> 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.</p> <p><b>For required element g:</b> 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.</p> <p><b>For required element h:</b> 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.</p> <p><b>For required element i:</b> The procedure could outline, for example, the frequency, staff member responsible, and elements of the media contact list that are reviewed and updated.</p>		

<b>MEASURE 2.2.5 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 protocol, process, or system	<b>Dated Within</b> 5 years
<p>2. An emergency communication protocol, process, or system for contacting response partners 24/7 during a public health emergency, which must include:</p> <p>a. A list of response partners that minimally includes health care providers, emergency management, emergency responders, and environmental health agencies.</p> <p>b. A description of how alerts are sent and received 24/7.</p>	<p>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.</p> <p>This requirement may be—but does <b>not</b> 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.</p> <p>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.</p> <p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p>		

**MEASURE 2.2.6 A:**

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## Assess potential hazards, vulnerabilities, and resources in the jurisdiction.

**Purpose & Significance**

The purpose of this measure is to assess the health department's evaluation of potential hazards, vulnerabilities, and resources in a specific jurisdiction. The analysis assists preparedness planning by identifying potential targets that will likely impact a given community.

<b>MEASURE 2.2.6 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 risk assessment	<b>Dated Within</b> 5 years
<p>1. Results of a risk assessment of potential hazards, vulnerabilities, and resources.</p>	<p>The intent of this requirement is to provide the results of a risk assessment of potential hazards or threats (e.g., chemical or nuclear facilities, floods, extreme weather events), vulnerabilities (e.g., aging infrastructure, limited resources, or human or community impact), and resources. A risk or hazard assessment can be used to inform strategies to meet the needs of populations who are at higher risk. The assessment assists preparedness planning by identifying vulnerabilities and prioritizing resources and programming should an emergency arise.</p> <p>The assessment does <b>not</b> need to be formal and could exist as part of a jurisdictional risk assessment (JRA), hazard analysis, Threat Hazard Identification Risk Assessment (THIRA), or standalone document. The health department does <b>not</b> need to lead the development of a risk assessment but could participate in an assessment conducted for the jurisdiction or region. The health department might consider data or information contained in the state/Tribal/community health assessment process. For example, the CHA might have identified community assets that could be considered as resources in the face of hazards or community members may have raised concerns about threats associated with extreme weather events as part of the discussion about health priorities.</p> <p><b><u>Documentation Examples</u></b> Documentation could be, for example, a hazard analysis, jurisdictional risk assessment, a memo, or a presentation or discussion during a meeting describing hazards, vulnerabilities and resources.</p>		

**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.

<b>MEASURE 2.2.7 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 plan	<b>Dated Within</b> 5 years
<p>1. A plan for conducting response exercises, which indicates how the elements in the EOP or annexes have been or will be tested.</p>	<p>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.</p> <p>Documentation could be, for example, a list or schedule of response exercises that indicates how each will test elements of the EOP or annexes.</p>		
<b>MEASURE 2.2.7 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 5 years
<p>2. After Action Report (AAR), which includes:</p> <p>a. Name of event or exercise.</p> <p>b. Overview of the event or exercise.</p> <p>c. Response partners involved.</p> <p>d. Notable strengths.</p>	<p>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.</p> <p><b>For required element a:</b> Provide the name of the event or exercise, which might relate to the scenario or event.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> Partners or participants could include, for example, federal, state, Tribal, or local 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.</p> <p><b>For required element d:</b> 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.</p>		

<b>MEASURE 2.2.7 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 5 years
<p>e. Listing and timetable for improvement(s).</p> <p>At least one of the AARs must show collaboration with other health departments (state, Tribal, or local) working together on an exercise or response.</p> <p>One example must include a Tribe, if one exists in the health department's jurisdiction.</p>	<p><b>For required element e:</b></p> <p>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.</p>		
<b>MEASURE 2.2.7 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>3. Improvements made based on AARs provided in Required Documentation 2.</p>	<p>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.</p> <p>The intent of this requirement is to show that a change has been made based on the AAR. It is <b>not</b> sufficient to provide an example of a planned change. If the linkage to the AAR is unclear, an explanation of how an AAR informed the change could be described in the Documentation Form.</p> <p>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.</p>		

**MEASURE 2.2.8 S:**

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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.

<b>MEASURE 2.2.8 S:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Information sought or reviewed to understand the needs of multiple Tribal or local health departments regarding developing, revising, or testing emergency operations plans.</p> <p>The example must include seeking or reviewing information about at least one Tribal health department and one local health department.</p> <p>If there is not a Tribal health department in the state this must be indicated in the Documentation Form.</p>	<p>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 <b>not</b> 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.</p> <p>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.</p> <p>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).</p> <p>The state health department <b>cannot</b> 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.</p> <p><b>Documentation Examples</b></p> <p>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.</p>		

<b>MEASURE 2.2.8 S:</b> <b>Required</b> <b>Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Support provided to Tribal or local health departments to be responsive to their needs in developing, revising, or testing emergency operations plans.</p> <p>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.</p>	<p>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.</p> <p>The state health department <b>cannot</b> 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.</p> <p>Examples could be related to the activities described in Required Documentation 1, but they do <b>not</b> need to be. The state health department may not be able to meet all the needs of Tribal or local 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.</p> <p>If the example does not indicate how the support is responsive to Tribal and local health department needs, an explanation can be provided in the Documentation Form. An assessment of needs or formal request for support is <b>not</b> 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.</p> <p><b>Documentation Examples</b>            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.</p>		

<b>MEASURE 2.2.8 S: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>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.</p> <p>If no emergencies have occurred within the last 5 years, documentation could be from a drill or exercise to test communications.</p>	<p>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.</p> <p>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.</p> <p>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.</p>		

## 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

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

<b>Standard 3.1:</b>	Provide information on public health issues and public health functions through multiple methods to a variety of audiences.
<b>Standard 3.2:</b>	Use health communication strategies to support prevention, health, and well-being.

### FOUNDATIONAL CAPABILITY MEASURES:

<b>Communications</b>	<b>3.1.1 A:</b>	Maintain procedures to provide ongoing, non-emergency communication outside the health department.
	<b>3.2.2 A:</b>	Implement and evaluate health communication efforts to encourage actions to promote health and well-being.

## STANDARD 3.1

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

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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.

<b>MEASURE 3.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 department-wide procedure or set of procedures	<b>Dated Within</b> 5 years
<p>1. Procedure for ongoing, non-emergency communications. The procedure must:</p> <p>a. Include the process for ensuring information is accurate and timely.</p> <p>b. Describe the approach to tailoring communication to different audiences.</p>	<p>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.</p> <p>If a health department works with an office of public affairs, then documentation can come from that office to meet these requirements.</p> <p><b>For required element a:</b>            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.</p> <p><b>For required element b:</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.</p> <p>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.</p>		

<b>MEASURE 3.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 department-wide procedure or set of procedures	<b>Dated Within</b> 5 years
<p>c. Include the process for coordinating with community partners to promote the dissemination of unified public health messages.</p> <p>d. Describe the process to maintain a contact list of key stakeholders for communications.</p> <p>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:</p> <ul style="list-style-type: none"> <li>i. Maintaining media relationships.</li> <li>ii. Creating appropriate, effective public health messages.</li> <li>iii. Managing other communications activities.</li> </ul>	<p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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 <b>not</b> required for this requirement.</p> <p><b>For required element e:</b> 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.</p> <p>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.</p>		

<b>MEASURE 3.1.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example that addresses a, b, and c or separate examples demonstrating each required element	<b>Dated Within</b> 2 years or current agreement
<p>2. Capacity to communicate with individuals who are:</p> <ul style="list-style-type: none"> <li>a. Non-English speaking.</li> <li>b. Deaf or hard of hearing.</li> <li>c. Blind or have low vision.</li> </ul> <p>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.</p>	<p>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.</p> <p>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.</p> <p>The services do <b>not</b> have to be provided directly by the health department but must be available when needed.</p> <p>Tribal health departments may have policies that demonstrate the promotion of culturally appropriate interactions between staff and community members. CHR or “Cultural Interpreters” may also be available to provide both translation and feedback from community members on program materials or services provided.</p>		
<b>MEASURE 3.1.1 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current relationship
<p>3. Relationship with the media, which includes:</p>	<p>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.</p> <p>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).</p>		

<b>MEASURE 3.1.1 A:</b> <b>Required</b> <b>Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current relationship
<p>a. What actions the health department has taken to proactively build relationships with specific media outlets.</p> <p>b. How the health department addresses media stories that include incomplete information or misinformation.</p>	<p><b>For required element a:</b>            The health department's approach to develop ongoing relationships with media outlets could include, for example, ensuring the health department is familiar with which reporters are assigned the health "beat;" making health department staff or governing entity representatives available for interviews or quotes; or providing editorials about public health issues.</p> <p><b>For required element b:</b>            The process for addressing incomplete or inaccurate information could include, for example, steps for monitoring news stories about public health, or strategies for proactively reaching out to news media with potential corrections or additional context for news stories.</p>		

**MEASURE 3.1.2 A:**

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Inform the public about public health's role and functions, and build a positive reputation of the health department in the community.

**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. 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. Branding uses a common visual identity to effectively convey the department's presence and functions, and to foster a positive reputation among community members.

<b>MEASURE 3.1.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 policy, procedure, or set of policies or procedures	<b>Dated Within</b> 5 years
<p>1. A department-wide brand strategy that includes policies or procedures for each of the following:</p> <p>a. Convey the health department's brand, which demonstrates the presence of the health department, its functions, and services to the entire community.</p> <p>b. Ensure that health department staff have a clear understanding and commitment to the health department's brand.</p> <p>c. Integrate brand messaging into department communication strategies.</p>	<p>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.</p> <p>Examples of how the branding strategy has been implemented would <b>not</b> 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.</p> <p><b>For required element a:</b>            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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b>            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).</p>		

<b>MEASURE 3.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 policy, procedure, or set of policies or procedures	<b>Dated Within</b> 5 years
<p>d. Use a common visual identity (logo) to communicate the health department's brand.</p>	<p><b>For required element d:</b> The policy or procedure could include, for example, guidelines on how and where to use the department logo.</p>		
<b>MEASURE 3.1.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example	<b>Dated Within</b> 5 years
<p>2. Implementation of the department-wide brand strategy, which must include:</p> <p>a. Communication about what public health is, what the health department does, and why it matters.</p> <p>b. Integration of brand messaging into department communication strategies, as described in Required Documentation 1.</p> <p>c. Use of a common visual identity (logo) to communicate the health department's brand, as described in Required Documentation 1.</p>	<p>The intent of this requirement is that the example demonstrate implementation of the brand strategy, including how the brand strategy externally conveys the presence of the health department and value of public health.</p> <p><b>For required element a:</b> Informational materials, brochures, or website screenshots might discuss the role, contributions, and programs or services provided by the health department. Overview presentations about public health, its role, value, and services; impact statements; or annual reports could also demonstrate methods to communicate about public health. The intent is that the health department provide information about the importance of the health department and public health that fosters understanding about public health's contributions. Messaging about how the public is part of public health can help populations better understand the personal collective responsibilities of a healthy community. Information about a single health department program or service would not meet the intent.</p> <p><b>For required element b:</b> The example will also reflect the brand messaging consistent with what is described in Required Documentation 1, which could include, for example, the health department's mission, vision, values, or how the health department provides value in the community.</p> <p><b>For required element c:</b> The health department logo will be included in the example.</p>		

MEASURE 3.1.2 A: Required Documentation 3	Guidance	Number of Examples Narrative description	Dated Within 5 years
3. A positive reputation fostered by the health department to build community trust.	<p>The intent of this requirement is for the health department to show how it actively works to promote a positive reputation and trust among community members. The effectiveness of the health department's services and messaging requires building trust and a positive reputation among community members.</p> <p>Improving visibility and awareness of public health and the health department is part of fostering a positive reputation. This could include, for example, efforts to elevate awareness about health department activities in the community (e.g., by having employees wear clothing with the health department brand) or how the health department is an ally with other trusted community organizations. Other examples could include a periodic survey among community members to assess awareness and trust in the health department's services or functions. The intent is not to show customer satisfaction for a particular program or service, <b>but instead</b>, the survey would relate to the health department as a whole. This measure focuses on the efforts to foster trust with members of the public, documentation about efforts to foster trust with other organizations would <b>not</b> meet the intent of this requirement.</p>		

**MEASURE 3.1.3 A:**

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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, assessment, and enhancement of a variety of methods and formats to keep the public informed about the health department, 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 and how they can be improved.

<b>MEASURE 3.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 website</b>	<b>Dated Within 1 year</b>
<p>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:</p> <p>a. 24/7 contact number for reporting health emergencies.</p> <p>b. Contact number or link to report notifiable or reportable conditions.</p> <p>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.)</p>	<p>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.</p> <p>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).</p> <p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p>Tribal health departments can decide through what means they make public health data available to their population or community. Data do <b>not</b> 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.</p>		

<b>MEASURE 3.1.3 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 website	<b>Dated Within</b> 1 year
<p>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.)</p> <p>e. Links to public health-related laws or codes including enforcement related laws.</p> <p>f. Links to permits and license applications, as applicable. (If not applicable, this may be indicated in the Documentation Form.)</p>	<p><b>For required element d:</b>            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.</p> <p>Tribal health departments can decide through what means they make public health data available to their population or community. Data do <b>not</b> 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.</p> <p><b>For required element e:</b>            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.</p> <p><b>For required element f:</b>            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.</p>		

<b>MEASURE 3.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 website	<b>Dated Within</b> 1 year
<p>g. Information about or materials from public health program activities conducted by the department.</p> <p>h. Links to CDC and other public health-related federal, state, or local agencies, as appropriate.</p> <p>i. The name of the health department director.</p> <p>j. The address of the health department.</p> <p>k. A method for the public to submit comments to the health department.</p> <p>l. Evidence of at least one update to the website within the past year.</p>	<p><b>For required element g:</b> Information or materials from program activities could include, for example, infectious disease, chronic disease, environmental public health, prevention, and health promotion.</p> <p><b>For required element h:</b> 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.</p> <p><b>For required element i:</b> 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.</p> <p><b>For required element j:</b> 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.</p> <p><b>For required element k:</b> 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.</p> <p><b>For required element l:</b> 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.</p>		

<b>MEASURE 3.1.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 3 years
<p>2. Web and social media strategies enhanced to communicate with the public.</p> <p>At least one example must be based on an assessment of current communication strategies. The health department must indicate which assessment finding(s) led to the new or enhanced web or social media strategy.</p> <p>One example must describe the health department's website or web page; the other example must address use of social media.</p>	<p>The example will illustrate how the health department's website and social media have been enhanced within the last three years to provide strategic communications to the general public. For example, the health department may describe reorganizing website content to streamline navigation or expanding use of social media platforms. For example, if the health department submits an example of a site map showing the new navigation, the Documentation Form can describe how the new navigation is an enhancement from the prior website.</p> <p>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.</p> <p>To understand what communications strategies may benefit from enhancements and to plan those improvements, health departments will assess their current strategies. For example, the health department could assess its website analytics (reach, hits, etc.) or social media analytics (page visits, new or total followers, impressions, or shares). A report of the assessment is <b>not</b> needed. Instead, the Documentation Form or narrative for one of the examples will describe how the change was a result of a specific finding from an assessment. For example, the narrative or Documentation Form could explain that the health department looked at the number of impressions for Twitter posts over time and identified that the tweets with the greatest number of impressions were those that incorporate trending hashtags or reference (tag) community partners and influencers. As a result, the health department began to more consistently look for opportunities to engage with partner organizations as appropriate, such as commenting, liking, and retweeting to increase reach and engagement.</p>		

## STANDARD 3.2

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

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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:**

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# Design and assess 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).

<b>MEASURE 3.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 department-wide approach (narrative description is acceptable)	<b>Dated Within</b> 5 years
<p>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:</p> <p>a. Determining that an issue is a priority for communication efforts.</p>	<p>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 <b>not</b> meet the intent of this requirement. This does <b>not</b> need to be prescriptive or formalized into a separate plan, 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.</p> <p>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.</p> <p><b>For required element a:</b>            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.</p>		

<b>MEASURE 3.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 department-wide approach (narrative description is acceptable)	<b>Dated Within</b> 5 years
<p>b. Identifying appropriate evidence-based or promising practices.</p> <p>c. Engaging the priority population(s) in the design, development, or implementation of strategies.</p> <p>d. Ensuring consistency with procedures for communications (Measure 3.1.1) about:</p> <ul style="list-style-type: none"> <li>i. Ensuring information is accurate and timely.</li> <li>ii. Tailoring communication for different audiences.</li> <li>iii. Informing or coordinating with community partners to promote the dissemination of unified public health messages.</li> </ul>	<p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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).</p> <p>Tribal health departments could include descriptions of talking circles, Tribal oversight committees, Tribal leader meeting, community meetings, or Tribal consultation meetings.</p> <p><b>For required element d:</b> 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.</p>		

<b>MEASURE 3.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 department-wide approach (narrative description is acceptable)	<b>Dated Within</b> 1 year
<p>e. Assessing how well implemented communication strategies are working.</p>	<p><b>For required element e:</b>            The intent of this requirement is that the health department describe the general approach it will use to assess whether implemented communications strategies are achieving intended goals. Assessing the effectiveness of strategies may identify and lead to changes in content, dissemination, or strategy. The approach to assessment could include, for example, feedback gathered from the target audience on the methods, frequency, and content of communication shared; analytics to determine communication reach; or ultimately, efforts to understand whether communications strategies were effective in achieving improved health outcomes or behavioral change. For example, the health department might evaluate the reach and extent to which individuals modified their behavior (e.g., initiated tobacco cessation, engaged in healthy eating or physical activity, received recommended vaccines) based on the health department's communication strategies. Methods to assess effectiveness of those communication strategies could include, for example, a survey or post-evaluation form from a training or event.</p> <p><b>Documentation Examples</b>            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.</p>		

**MEASURE 3.2.2 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Implement and evaluate health communication efforts to encourage actions to promote health and well-being.

**Purpose & Significance**

The purpose of this measure is to assess the health department's implementation and evaluation of communication campaigns designed to foster actions to promote health and address preventable health conditions. Communication campaigns use multiple modes in order to reach broader audiences. Assessing communications efforts enables health departments to determine how to most effectively influence health behaviors.

<b>MEASURE 3.2.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>I. Communications campaigns implemented to provide accurate information to the public to address health risks, health behaviors, disease prevention, or well-being, which include:</p> <p>a. A description of how community voice and public health research were incorporated to help shape the final content of information provided to the public.</p> <p>b. The final content that references an action that members of the public should take and describes why the action should be taken.</p> <p>c. A description of how the health department strived for cultural humility and linguistic appropriateness.</p>	<p>The intent of this requirement is to demonstrate how the health department has implemented a campaign that uses multiple modes to communicate about the same public health issue. A communication effort that is only disseminated through one mode (for example, a public service announcement alone) would <b>not</b> meet the intent of this requirement.</p> <p>Public health information can address a broad range of public health promotion messages:</p> <ul style="list-style-type: none"> <li>• Health risks, for example, high blood pressure or high cholesterol.</li> <li>• Health behaviors, for example, tobacco use, exercise habits, or unprotected sexual activity.</li> <li>• Disease, illness, or injury prevention, for example, seat belt use or immunizations.</li> </ul> <p>Health information could address a combination of topics and messages. For example, unprotected sex, needle sharing, and HIV transmission could combine aspects of health risks, health behaviors, and prevention.</p> <p>Chronic disease program areas could include, for example, diabetes, obesity, heart disease, HIV, or cancer.</p> <p><b>For required element a:</b> Public health research could 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.</p> <p>To demonstrate incorporation of community voice, the health department could describe how it sought input from the priority audience during the development of messages in order to help shape the final content. Feedback after messages are delivered would <b>not</b> be appropriate, unless the documentation shows how the health department modified the content or dissemination strategy and delivered the revised version.</p> <p><b>For required element b:</b> The final content will convey action members of the public should take with a description of the reason(s). For example, a youth tobacco campaign might include a PSA recommending teenagers avoid vaping or other tobacco products and a billboard with a URL for a resource for parents about how to talk with their teenage children because of the associated health risks.</p> <p><b>For required element c:</b> Health promotion messages could, for example, be offered in multiple languages, include simplified wording and plain language, include visual aids for those of low literacy, 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 to ensure cultural awareness and relevance.</p>		

<b>MEASURE 3.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>d. Description of how the communications campaign information was shared or distributed through multiple modes.</p> <p>The examples must come from two different public health topics, one of which must address the prevention of a chronic disease.</p>	<p><b>For required element d:</b></p> <p>To be considered a campaign, the same topic will have been addressed through multiple modes. For example, a campaign to encourage vaccination might include a combination of social media posts, public service announcements, billboards, posters displayed in public transportation stops or grocery stores, and television and radio interviews. Distribution might also include public forums, health fairs or events, or presentations.</p>		
<b>MEASURE 3.2.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Evaluation of communications strategies implemented.</p> <p>The evaluation must be one of the examples provided in Required Documentation 1.</p>	<p>The evaluation does <b>not</b> need to be complex or costly (i.e., the health department need not contract with an external marketing or communications vendor).</p> <p>The health department could evaluate, for example, the degree to which the selected evidence-based or promising practices were appropriately tailored to meet community needs; whether other practices might have been used to elevate community voice; whether the message was communicated in a culturally and linguistically appropriate manner; or whether the campaign was effective in achieving improved health outcomes or behavioral change. The evaluation might also include consideration of communication methods or modes (e.g., was social media or the website the best vehicle to reach target audiences or could methods be more effective, perhaps by examining website or social media analytics to determine reach and engagement).</p> <p><b>Documentation Examples</b></p> <p>Documentation could be, for example, meeting minutes showing discussion of evaluation findings among staff, a presentation, report.</p>		

## DOMAIN

## 4

## 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:

<b>Community Partnership Development</b>	<b>4.1.2 A:</b>	Participate actively in a community health coalition to promote health equity.
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## STANDARD 4.1

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

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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:**

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# Foster cross-sector collaboration to advance equity.

**Purpose & Significance**

The purpose of this measure is to assess the health department's general approach to engagement in cross-sector collaborations to advance equity. Cross-sector collaboration and alignment involves fostering trust and working towards shared goals.

<b>MEASURE 4.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current process
<p>1. Approach to cross-sector collaboration or alignment. The narrative must describe:</p> <p>a. How the health department has fostered a culture of trust with other sectors.</p>	<p>Addressing complex and evolving community factors that influence health involves cross-sector collaborations aligned towards achieving shared goals. Cross-sector collaborations demonstrate a commitment to community, require trust and humility, and establish a space for collaboration. They can spur innovation as they require strategic engagement that touches on multiple social and structural determinants of health and require partners to come together and be creative in addressing issues collectively.</p> <p>Cross-sector collaboration and alignment involves working towards a shared vision or common goal, communicating consistently and transparently, sharing data indicating progress towards achieving goals, and leveraging resources to sustain progress. Collaborations that work toward advancing equity and transforming how a community works together will include a broad, diverse array of cross-sector partners that include the community, organizations that represent historically excluded and marginalized populations, and traditional partners (e.g., local government, not-for profits, for-profits, community organizations, the media, or health care).</p> <p>The narrative could address the approach the health department has used in various collaborations, whether the health department has convened them or actively participated in them.</p> <p><b>For required element a:</b>            Fostering a culture of trust requires open communication. Trust takes time to establish and benefits from consistent commitment. The description could include how the health department, for example:</p> <ul style="list-style-type: none"> <li>• Engages in active listening;</li> <li>• Ensures resources are available (including adequate staff time) to build relationships;</li> <li>• Seeks to be allies or participate in alliances to demonstrate their genuine interest in working collaboratively towards a shared purpose;</li> <li>• Puts a process in place to be responsive or ensure follow through on commitments (e.g., having a staff person whose responsibilities include managing the ongoing relationships or including related goals in performance management or strategic planning processes to hold the health department accountable to being a trustworthy partner); or</li> <li>• Demonstrates ability to adjust goals to meet mutual interests of partners across sectors (e.g., building in opportunities to gather information about partners' priorities while establishing the health department's goals).</li> </ul>		

<b>MEASURE 4.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current process
<p>b. Process(es) or framework(s) used by the health department to advance equity and foster inclusiveness with other sectors and with organizations or community members that represent historically excluded or marginalized populations.</p>	<p><b>For required element b:</b>            The description could include how the health department seeks out other sectors and organizations or community members that have not historically engaged with the health department or who have been marginalized. The collaboration might include community members directly or include organizations representing those populations that are disproportionately affected by conditions that create poorer health outcomes or for whom systems of care are not always appropriately designed. It will also describe the process(es) or framework(s) used to advance equity. This might include, for example, engaging in collaborative decision making or using power mapping to identify additional sectors or partners to promote change and to understand how power is distributed across those partners. Frameworks could include, for example, the Framework for Aligning Sectors from the Robert Wood Johnson Foundation; Communities in Action: Pathways to Health Equity; Collective Impact; Bay Area Regional Health Inequities Initiative (BARHI); or health equity impact assessments.</p>		

**MEASURE 4.1.2 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Participate actively in a community health coalition to promote health equity.

**Purpose & Significance**

The purpose of this measure is to assess the health department's engagement in collaboration with other sectors to advance equity. Coalitions provide the opportunity to leverage resources, incorporate various perspectives and expertise from communities the health department serves, 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.

<b>MEASURE 4.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Cross-sector coalition that advances equity or health equity. The example must include:</p> <p>a. A shared purpose and priorities. At least one priority must relate to equity or health equity.</p> <p>b. A participant list, which must include health sector, non-health sector, and community members. At least one organization or community member must represent historically excluded or marginalized populations.</p> <p>c. A description of how data or data findings are shared.</p>	<p>The intent of this requirement is to provide an example of an active and ongoing cross-sector coalition in which the health department participates. Advancing equity does <b>not</b> need to be the primary focus of the coalition, but the coalition will have at least one priority that relates to equity. The coalition could be the state/ Tribal/local health assessment or health improvement plan partnership or a sub-group of that partnership.</p> <p><b>For required element a:</b> Describe the coalition's mutual understanding or shared purpose and priorities, which could be based on a significant challenge (e.g., cost, poor health outcomes, or inequities), a philosophical or historical injustice (e.g., service to a vulnerable population), or external or internal circumstances (e.g., community input, political or funding expectations). The shared purpose will reflect the intended purpose and priorities of what the collaboration with other sectors aims to achieve.</p> <p><b>For required element b:</b> Various sectors could include, for example, local government (e.g., elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, or schools boards), for-profits (e.g., businesses, industries, and major employers in the community), not-for profits (e.g., chamber of commerce, civic groups, local mortality review committee or board, public health institutes, environmental public health groups, or groups that represent minority health), community foundations and philanthropists, voluntary organizations, health care providers (including hospitals), entities that represent historically excluded populations (for example, minority-owned business, community-based organizations [CBOs], Black-led or other minority-led media, or non-dominant religious groups), academia, or other health departments (state, Tribal, local, or military).</p> <p>Community members could include, for example, individual residents that have expressed an interest, community members with lived experience (e.g., those with personal knowledge gained through direct or first-hand experience), or individuals that are seen in their communities as leaders. Community members are intended to be members of the public. Including government employees or public health or health care professionals would <b>not</b> meet the intent of this requirement.</p> <p><b>For required element c:</b> For the purpose of this requirement, sharing data may include a range of ways of making information available among partners, including, for example, developing ongoing mechanisms to exchange data, putting in place data use agreements to share specific data sets, working together to design and implement a new data collection initiative, or providing presentations or reports of data findings.</p>		

<b>MEASURE 4.1.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>d. A description of the decision-making process, including how the community is involved in decision making.</p> <p>e. A common way of assessing progress towards outcomes.</p> <p>f. Efforts to explore sustainability of the coalition.</p>	<p><b>For required element d:</b>            The decision-making process could include, for example, the governance infrastructure of the coalition, such as leadership of a multisector steering committee or oversight committee, with defined roles and relationships across the coalition. The description could also explain processes that allow for participation by all parties in making decisions and gathering community input, such as holding public forums or open meetings; or having transparent, deliberative processes for determining how the perspectives of partners and engaged community members are honored and included in decision-making.</p> <p><b>For required element e:</b>            Using a common strategy for assessing progress will reinforce having a mutual understanding of the shared purpose. Progress could assess improving health outcomes or outcomes related to, for example, strengthening social engagement, increasing social capital, strengthening trust, increasing shared accountability, or improving community resilience.</p> <p><b>For required element f:</b>            Sustaining the collaborative work could entail leveraging the expertise, assets, or resources of participants and the community. Community assets include individuals, citizen associations, local institutions, political leaders, businesses and industries, nonprofits, faith-based organizations, informal community leaders, government agencies, voluntary organizations, community foundations, arts and cultural organizations, the built environment (e.g., parks and walking trails), or intangible assets (e.g., related to social capital and civic engagement).</p> <p>It could also involve collaboratively seeking sustainable funding, for example, pursuing grant funding or using innovative financial models that including blending and braiding funding (e.g., establishing local wellness funds). Having mechanisms to hold the coalition accountable for how they use those resources is an important step to building trust.</p>		

## MEASURE 4.1.3 A:

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# 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.

<b>MEASURE 4.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Strategy implemented to promote active participation or eliminate barriers to participation among community members, consistent with an adopted community engagement model or framework.</p>	<p>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.</p> <p>The example will reference the model or framework used by the health department. If the model or framework is not evident in the example, it could be indicated in the Documentation Form. Community engagement models or frameworks include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Community-Based Participatory Research (CBPR), or other community engagement framework or model. The model or framework could be one adapted or created by the health department. These models could be used to determine areas of need, level of engagement, range of collaboration, or willingness and readiness of the community to engage and maintain health behaviors.</p> <p>Examples of strategies could include:</p> <ul style="list-style-type: none"> <li>• Implementing a leadership/civic engagement academy that gives community members the opportunity to build their capacity.</li> <li>• Offering mini-grants to support community-led initiatives.</li> <li>• Engaging in participatory budgeting (e.g., letting community members participate in decision making about how to allocate a set amount of financial resources).</li> <li>• Providing transportation mechanisms or childcare to facilitate participation by community members.</li> <li>• Providing compensation (monetary or nonmonetary) for time and contributions.</li> <li>• 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).</li> <li>• Enhancing residents' capacity to understand levers of power or influence in policy change.</li> <li>• 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.</li> </ul>		

<b>MEASURE 4.1.3 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
	<ul style="list-style-type: none"> <li>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.</li> </ul> <p><b><u>Documentation Examples</u></b>            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.</p>		

## 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:

<b>Policy Development and Support</b>	<b>5.1.1 A:</b>	Examine and contribute to improving policies and laws.
<b>Community Partnership Development</b>	<b>5.2.1 A:</b>	Adopt a community health improvement plan.
<b>Equity</b>	<b>5.2.3 A</b>	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.

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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:**

## 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.

<b>MEASURE 5.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>I. A review of a current or proposed policy or law shared with those who set or influence policy. Each review must include:</p>	<p>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 <b>not</b> be sufficient if documentation only demonstrates belonging as a member or receiving legislative or policy news or updates.</p> <p>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.</p> <p>Policies that only affect the health department's staff (e.g., HR policies) do <b>not</b> meet the intent of this requirement. Documentation can address policies either in effect or proposed and can address policies at the federal, state, Tribal, or local level . The policies or laws may relate to executive orders at the state or local level or consider policy-related advisories or recommendations.</p> <p>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.</p> <p>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.</p> <p>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 <b>not</b> 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.</p>		

<b>MEASURE 5.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>a. Consideration of evidence-based practices, promising practices, or practice-based evidence.</p> <p>b. Assessment of the impacts of the policy or law on equity.</p> <p>c. Input gathered from stakeholders or strategic partners.</p> <p>For state health departments at least one stakeholder in required element c must be a local or Tribal health department(s).</p> <p>Documentation must include both the review <b>and</b> how it was shared.</p>	<p><b>For required element a:</b>            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.</p> <p>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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b>            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.</p>		

<b>MEASURE 5.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
	<p>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.</p> <p>It is <b>not</b> 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.</p> <p><b><u>Documentation Examples</u></b>            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.</p> <p>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.</p> <p>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.</p>		

## STANDARD 5.2

# Develop and implement community health improvement strategies collaboratively.

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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:**

## 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.

<b>MEASURE 5.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> <b>1 plan</b>	<b>Dated Within</b> <b>5 years</b>
<p>1. A community health improvement plan (CHIP), which includes all of the following:</p> <p>a. At least two health priorities.</p> <p>b. Measurable objective(s) for each priority.</p> <p>c. Improvement strategy(ies) or activity(ies) for each priority.</p> <p>i. Each activity or strategy must include a timeframe <b>and</b> a designation of organizations or individuals that have accepted responsibility for implementing it.</p>	<p>This may be referred to as a state health improvement plan, Tribal health improvement plan, or other name.</p> <p>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 <b>not</b> fulfill the purpose of the health improvement plan to address the jurisdiction's priorities.</p> <p><b>For required element a:</b> The CHIP will designate two or more health priorities to be addressed collaboratively.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p>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 <b>not</b> need to be formal, such as an MOA or MOU.</p>		

<b>MEASURE 5.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> <b>1 plan</b>	<b>Dated Within</b> <b>5 years</b>
<p>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.</p> <p>d. Identification of the assets or resources that will be used to address at least one of the specific priority areas.</p> <p>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.</p>	<p>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.</p> <p><b>For required element d:</b> 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 <b>not</b> 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).</p> <p><b>For required element e:</b> 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.</p>		

**MEASURE 5.2.2 A:**

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## Encourage and participate in collaborative implementation and revision of the community health improvement plan.

**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.

<b>MEASURE 5.2.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Implementation of a community health improvement plan (CHIP) strategy or activity, including:</p> <ul style="list-style-type: none"> <li>a. Which CHIP priority the example addresses. (This may be indicated in the Documentation Form.)</li> <li>b. The health department's role in the implementation.</li> <li>c. Results of the strategy or activity.</li> </ul> <p>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 activity or strategy and the prior CHIP. Although the prior CHIP may be more than 5 years old, the implementation must have occurred within 5 years.)</p> <p>The CHIP process must address the jurisdiction as described in the description of Standard 5.2.</p>	<p>The intent of the requirement is to provide documentation of the implementation of a state/Tribal/community health improvement plan (CHIP) strategy or activity, rather than a full review of progress on all CHIP strategies or activities. The example could be of a success (e.g., a story about an achievement that the CHIP collaborative shared with the community) or unsuccessful implementation, including what was learned based on the implementation of a specific community health improvement strategy or activity.</p> <p><b>For required element a:</b> The Documentation Form may be used to indicate which CHIP priority the activity is aligned with.</p> <p><b>For required element b:</b> The health department does <b>not</b> 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. For example, the health department might tell the story of implementing fresh food alternatives by working with a local extension program and other partners to establish farmers markets or fresh offerings at convenience stores within identified food deserts.</p> <p><b>For required element c:</b> The example will also address what was accomplished as a result of the activities. In the farmers market example, this could include whether the strategy was successful in increasing healthy food purchases, feedback from participants, or longer-range outcomes, such as reducing chronic conditions. Describing the impact on health or health equity may help the CHIP partnership demonstrate the value of population health interventions.</p> <p><b><u>Documentation Examples</u></b> If provided as documentation, the example could include, for example, a news article, meeting materials, excerpt of an annual report, a grant that was received, or presentation demonstrating how the strategy or activity was implemented.</p>		

<b>MEASURE 5.2.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Community health improvement plan (CHIP) strategy or activity that was revised, in collaboration with partners.</p> <p>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 activity or strategy and the prior CHIP. Although the prior CHIP may be more than 5 years old, the revision must have occurred within 5 years.)</p> <p>The CHIP process must address the jurisdiction as described in the description of Standard 5.2.</p>	<p>The intent of this requirement is to provide a specific example demonstrating how the CHIP is a living document that continues to evolve after it is released. An example about how a strategy or activity from one cycle of the CHIP was improved in the second cycle would <b>not</b> meet the intent of the requirement. Strategies may need revision or new strategies may be added based on a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. Changes will be developed in collaboration with partners and stakeholders involved in the planning process. The intent is that at least some of the partners involved in the CHIP (e.g., one of the workgroups) are engaged when making changes. It is not necessary for the entire CHIP partnership to be involved.</p> <p>Documentation could include, for example, an addendum to the CHIP showing the revision, meeting minutes or a presentation showing the change, or a revised workplan.</p>		

**MEASURE 5.2.3 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 efforts to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities, as well as to build environmental resiliency. 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. The implications of climate change (e.g., increased extreme weather, air pollution) often disproportionately affect populations already at higher risk of poorer health outcomes. Consequently, health departments have a critical role in working with community to address and prevent those adverse effects.

<b>MEASURE 5.2.3 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>I. 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.</p> <p>The documentation must define the health department's role in the strategy as well as the roles of stakeholders, partners, or the community.</p>	<p>The example could be related to strategies in the state/Tribal/community health improvement plan, but it does <b>not</b> need to be. The health department does <b>not</b> 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 <b>not</b> be sufficient for this requirement.</p> <p>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.</p> <p>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.</p> <p><b><u>Documentation Examples</u></b>            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.</p>		

<b>MEASURE 5.2.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
2. Efforts taken that contribute to building environmental resiliency.	<p>The intent of this requirement is that health departments are actively exploring, planning for, or developing strategies or policies that build environmental resilience against climate effects. Efforts may be led by the health department, or the health department might participate in efforts in partnership with others. The example could include successful or unsuccessful efforts, including what was learned based on the efforts taken by the health department.</p> <p>Efforts could include, for example, meetings with partners to discuss strategies to reduce the likelihood or severity of natural disasters or extreme weather events, working with a university to develop a report that includes how the health of the jurisdiction's population is affected by the environment with particular attention to how those policies might have an impact on communities that face higher health risks or other historical vulnerabilities, supporting a local initiative that supports community gardening and local produce so that less food is brought in from outside the local region, or working with other agencies on tree canopy expansion. Strategies or policies could include, for example, future planning to prevent or mitigate the effects of climate on health or to reduce greenhouse gas emissions or carbon footprints (e.g., policies to reduce idling of trucks or buses) or to promote clean energy. Documentation could include submitted grant applications (funded or unfunded) that address infrastructure changes, such as community design changes to mixed-use zoning, transportation redesign, or walkability.</p>		

## 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:

<b>Policy Development &amp; Support</b>	<b>6.1.2 A:</b>	Monitor and improve enforcement activities to assure accordance with protocols.
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## STANDARD 6.1

### Promote compliance with public health laws.

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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:**

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# Monitor and improve inspection activities.

**Purpose & Significance**

The purpose of this measure is to assess the health department's standardized approach to implement inspection activities. Monitoring inspection activities ensures protocols are consistently and effectively applied to contain or mitigate health hazards and problems.

<b>MEASURE 6.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> <b>Report (narrative</b> <b>description is</b> <b>acceptable)</b>	<b>Dated Within</b> <b>5 years</b>
<p>1. Inspection activities of regulated entities reviewed to ensure that:</p> <p>a. Regular <b>and</b> complaint investigations are performed in accordance with protocols.</p> <p>b. Inspections are performed according to defined frequency.</p> <p>The health department will provide both a description of the method for the review <b>and</b> the findings from the review for at least one enforcement program/area.</p> <p>If the health department is <b>not</b> mandated to perform inspections, required element a must describe the review process related to how the health department communicates about complaints to entities with enforcement authority. <b>No</b> additional documentation is needed for required element b.</p>	<p>The intent of this requirement is to show that the health department has a process to review inspection activities (including both those that are the result of complaints and those that are conducted on a routine basis) to ensure they are carried out according to protocols.</p> <p><b>For required element a:</b> The health department could describe, for example, how it reviews investigation reports to see that they follow the steps in the protocols (e.g., initiating investigations by logging concerns or complaints received, conducting initial investigations with reports of findings, or generating communications to regulated entities of what is needed to achieve compliance). The approach could include, for example, an audit of a random sample of investigation reports.</p> <p>If the health department is <b>not</b> mandated to perform inspections, the narrative or report could include, for example, how it ensures that complaints received by health department staff are handed off with appropriate timeliness to enforcement agencies.</p> <p><b>For required element b:</b> The narrative or report could include, for example, how the health department confirms that investigations of regulated entities (e.g., food service establishments, drinking water, septic systems, recreational water places, hotels, motels, body art facilities, camps, schools, daycare, or smoke-free ordinances) are carried out in the frequency defined by law or its algorithms. In addition to describing how the review happens, the documentation will include findings from that review (e.g., the proportion of investigations that are carried out in the appropriate timeframe).</p>		

**MEASURE 6.1.2 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Monitor and improve enforcement activities to assure accordance with protocols.

**Purpose & Significance**

The purpose of this measure is to assess the health department's standardized approach to implement enforcement actions. Monitoring enforcement activities ensures protocols are consistently and effectively applied to contain or mitigate health hazards and problems. If the health department has no enforcement authority, this measure does **not** apply.

<b>MEASURE 6.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Enforcement protocol(s) or policy(ies) reviewed and updated as needed.</p> <p>If the health department has no enforcement authority, this will be indicated to PHAB and <b>no</b> documentation is needed for this requirement.</p>	<p>The intent of this requirement is to demonstrate enforcement protocols or policies have been reviewed and updated since the health department's last round of accreditation (either initial or reaccreditation). Updates may be formal (e.g., specific revisions to protocols), part of a quality improvement project (e.g., examining process flow changes for improved efficiency), or part of a more informal effort (e.g., general changes to enforcement steps or staffing). If <b>no</b> updates are made, the health department will describe the review process and why no changes were warranted.</p>		
<b>MEASURE 6.1.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> Process (narrative description is acceptable)	<b>Dated Within</b> 5 years
<p>2. The process for reviewing the activities of one enforcement program/ area to ensure that they are performed in accordance with protocols.</p> <p>If the health department has no enforcement authority, this will be indicated to PHAB and <b>no</b> documentation is needed for this requirement.</p>	<p>The intent of this requirement is to show that the health department has a process to review or audit enforcement activities to ensure they are carried out according to protocols. This could include, for example, the process used to assess if protocols were followed appropriately when issuing notices of violation or compliance plans to regulated entities; whether follow up was performed according to schedule based on violations identified; whether appropriate action was taken to coordinate enforcement with other agencies, when appropriate; or whether appropriate steps were taken when violations persist, such as, suspension or revocation of licenses or closures.</p>		

## MEASURE 6.1.3 A:

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# 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.

<b>MEASURE 6.1.3 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 5 years
<p>1. Assessment of enforcement programs, which must include:</p> <p>a. A summary of patterns or trends in complaints, enforcement activities, or compliance.</p> <p>b. What worked well.</p> <p>c. What issues arose.</p> <p>d. Recommended changes in investigation, enforcement procedures, or other actions to improve compliance.</p> <p>The examples must be from two different enforcement programs.</p> <p>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.</p>	<p>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.</p> <p><b>For required element a:</b>            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.</p> <p>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.</p> <p>A list of enforcement activities or complaints would <b>not</b> meet the intent of this required element.</p> <p><b>For required elements b and c:</b>            The intent of these required elements is to evaluate the health department's processes (<b>not</b> 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 <b>not</b> to show what worked well or was problematic for a single investigation, <b>but instead</b> to evaluate the enforcement program's activities and processes, based on a review of its patterns or trends.</p> <p><b>For required element d:</b>            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.</p>		

<b>MEASURE 6.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 5 years
<p>If the health department has no enforcement authority, it must be indicated to PHAB and <b>no</b> documentation is needed for this requirement.</p> <p>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.</p>			
<b>MEASURE 6.1.3 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>2. Changes to investigation procedures, enforcement procedures, or other actions taken to improve compliance.</p> <p>If the health department has no enforcement authority, it must be indicated to PHAB and <b>no</b> documentation is needed for this requirement.</p>	<p>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.</p> <p>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.</p>		

<b>MEASURE 6.1.3 A:</b> <b>Required</b> <b>Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>3. Communication provided to the public on the purpose of public health regulations.</p> <p>The example must include evidence that the information was shared or distributed by the health department, regardless of the entity that created the communication.</p> <p>Examples must be from two different enforcement areas.</p>	<p>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.</p> <p>Communications with the public could be about the purpose of, for example, tobacco-free ordinances, restaurant inspections, or public health nuisance regulations.</p> <p>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.</p> <p>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.</p> <p><b>Documentation Examples</b>          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.</p>		

**MEASURE 6.1.4 A:**

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Ensure investigation or enforcement activities are carried out collaboratively and equitably.

**Purpose & Significance**

The purpose of this measure is to assess the health department's capacity to strengthen its coordination with other entities in support of investigation or enforcement activities and to ensure that investigation or enforcement activities are equitably applied. Ensuring the equitable application of investigations or enforcement activities is a component of efforts to promote justice and remedy past injustices.

<b>MEASURE 6.1.4 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Improved coordination with other entities in conducting investigation or enforcement actions.</p>	<p>The intent of this requirement is to provide an example of how the health department has improved coordination with other entities engaged in conducting investigation or enforcement actions (e.g., coordinating with regulators or others with enforcement authority). An example of improving coordination with regulated entities would <b>not</b> meet the intent of this requirement.</p> <p>The health department could, for example, describe how it collaborated to improve information sharing across agencies or departments through meetings or correspondence before or while following up on a complaint or issuing enforcement actions. Other examples could address strengthening coordination to ensure enforcement actions are performed consistently or improved processes to promote compliance, such as collaborating with another enforcement entity to develop training or educational materials to improve compliance among regulated entities.</p> <p>Either the health department or the other entity(ies) may have the inspection or enforcement authority.</p>		
<b>MEASURE 6.1.4 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Step(s) the health department has taken to ensure investigation or enforcement activities are equitably applied.</p> <p>If the health department has no enforcement authority, the health department must provide an example of how it has collaborated with an entity with enforcement authority to address the equitable application of investigation or enforcement activities.</p>	<p>The example may consider equity aspects of conducting investigations or enforcement activities, or both. It could include, for example, a description of successes or unsuccessful implementation, including what was learned about inequitable application of investigation or enforcement activities and plans to advance equity or revise investigation protocols to assure more equitable application.</p> <p>Equitable considerations for investigations could include, for example, steps taken to ensure investigations receive equal response time or follow up, regardless of the location's median income or poverty level; working with landlords to promote equity among those whose voices are not always heard and who reside in low-income housing; ensuring high-quality language assistance services are available to promote understanding and demonstrate respect during interactions with regulated entities; or working with people who are disenfranchised or unempowered to investigate or enforce lead abatement, nuisance violations, or safe drinking water. 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.</p> <p>If the health department has no enforcement authority, the example could describe a success story or learnings of how the health department worked with an entity(ies) with authority to address equitable investigation or enforcement practices or worked to strengthen relationships to examine enforcement practices that advance equity. The health department could, for example, form or participate in an equity taskforce or other collaboration to ensure enforcement actions do not harm, discriminate, or undermine the health of groups who are at higher risk or to ensure enforcement practices are carried out in an equitable way or wrongdoers are held accountable using consistent standards or enforcement provisions.</p>		

## 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:

<b>Community Partnership Development</b>	<b>7.2.1 A:</b> Collaborate with other sectors to improve access to social services.
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## STANDARD 7.1

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

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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:**

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# 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, as well as emerging issues which have implications on the health care delivery system or access to care among community members. This information could be useful in developing strategies or seeking support to expand services.

<b>MEASURE 7.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 assessment</b>	<b>Dated Within 5 years</b>
<p>1. A collaborative assessment of access to health care that includes the following:</p> <p>a. A list of partners that were involved, which must include primary care and behavioral health providers.</p>	<p>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).</p> <p>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.</p> <p>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.</p> <p><b>For required element a:</b> 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).</p>		

<b>MEASURE 7.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 assessment	<b>Dated Within</b> 5 years
<p>b. Review of data on populations who lack access or experience barriers to care.</p> <p>c. Review of data on the availability and gaps in services.</p> <p>d. Conclusions drawn about the causes of barriers to access to care.</p>	<p><b>For required element b:</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.</p> <p><b>For required element c:</b>            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.</p> <p><b>For required element d:</b>            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 <b>not</b> need to.</p>		

<b>MEASURE 7.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 assessment	<b>Dated Within</b> 5 years
<p>e. Emerging issues related to access to care.</p> <p>Primary care and behavioral health care must each be considered</p>	<p>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.</p> <p><b>For required element e:</b>            Emerging issues that impact access to health care could include, for example, changes in the structure of the health care system; types and numbers of health care professionals being trained; changes in reimbursement structure, rates, or payment mechanisms such as accountable care organizations; developing care models (e.g., coordinated care organizations or convenient care clinics); and innovative use of electronic medical record data. The consideration of emerging issues could be part of the collaborative assessment or may be conducted by the health department through processes such as an environmental scan; Strengths Weaknesses, Opportunities and Threats (SWOT) or Strengths, Opportunities, Aspirations, and Results (SOAR) Analysis; or forces of change (FOC) assessment with conclusions shared back to the collaborative group. The Documentation Form could be used to describe how the documented issues reviewed are emerging for the communities served.</p> <p><b>Documentation Examples</b>            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.</p>		

## MEASURE 7.1.2 T/L:

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

### **Purpose & Significance**

The purpose of this measure is to assess the **Tribal/local 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 competence, 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.

<b>MEASURE 7.1.2 T/L:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>1. Collaborative implementation of a strategy to assist the population in obtaining health care services.</p>	<p>The health department does <b>not</b> 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 <b>not</b> meet the intent of the requirement, which is to show collaborative implementation.</p> <p>Examples could include documentation that indicates the health department's role in the following:</p> <ul style="list-style-type: none"> <li>• Building relationships with payers and healthcare providers, including the sharing of data across partners to foster health and well-being.</li> <li>• Coordinating and integrating categorically funded behavioral, public health, and primary care services.</li> <li>• Collaborating with organizations representing different cultural groups on a campaign to reduce stigma associated with seeking behavioral health services.</li> <li>• Increasing the availability or methods to access timely care through telehealth services or other mechanisms.</li> <li>• Arranging for transportation mechanisms or coordination of services, for example, for individuals who are home bound.</li> <li>• Collaborating with partners on strategies to use community health workers, community health representatives, patient navigators, traditional healers, Clan Mothers, or members of the community.</li> <li>• Establishing a continuum of care model, for example, for substance abuse by working with behavioral health or first responders.</li> <li>• 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).</li> </ul> <p>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).</p> <p><b>Documentation Examples</b>            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.</p>		

<b>MEASURE 7.1.2 T/L:</b> <b>Required</b> <b>Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example	<b>Dated Within</b> 5 years
<p>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.</p> <p>The evaluation must relate to one of the examples in Required Documentation 1.</p>	<p>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 <b>not</b> 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.</p> <p>Findings that summarize the results of the evaluation will be provided. The feedback collected from individuals is <b>not</b> required. The Documentation Form may be used to describe who participated in the evaluation.</p> <p>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).</p> <p>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.</p> <p><b>Documentation Examples</b>            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.</p>		

## MEASURE 7.1.2 S:

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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.

<b>MEASURE 7.1.2 S:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Effort to develop or improve systems for ensuring the availability of health care.</p>	<p>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.</p> <p>State health departments could engage in these efforts collaboratively and do <b>not</b> 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 financiers (e.g., Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs), Medicaid or Medicare). General planning, such as a one-time discussion, would <b>not</b> meet the intent of the requirement which is to show engagement in the effort.</p> <p>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).</p> <p><b>Documentation Examples</b>            Documentation could include, for example, reports or other summaries of activities, meeting minutes showing activities, testimony, presentations, grant applications, or grant implementation.</p>		

## STANDARD 7.2

### Connect the population to services that support the whole person.

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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.

<b>MEASURE 7.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>1. Multi-sector implementation of an effort to improve access to social services or to integrate social services and health care.</p>	<p>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.</p> <p>The health department does <b>not</b> 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.</p> <p>Examples that focus on the needs of the whole person might address prevention or upstream services, or integration of physical and behavioral health concepts.</p> <p>A one-time discussion would <b>not</b> 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.</p> <p><b>Documentation Examples</b>            Documentation could include, for example:</p> <ul style="list-style-type: none"> <li>• A signed Memoranda of Understanding (MOU) between partners that lists activities, responsibilities, scope of work, and timelines.</li> <li>• A documented cooperative system of referral between partners that shows the methods used to link individuals with needed health care and social services.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>		

<b>MEASURE 7.2.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• Grant applications submitted by community partnerships that address increased access to health care and social services.</li> <li>• Subcontracts in the community to deliver health care and social services in convenient and accessible locations.</li> <li>• Program/work plans documenting strategies that improve access to social services that were developed collaboratively and include roles and timelines for activities.</li> <li>• Documentation of transportation programs that improve access to social services or transport between long-term care, nursing homes, and hospital stays.</li> </ul>		

## MEASURE 7.2.2 A:

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# 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.

<b>MEASURE 7.2.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Collaborative strategy to ensure continuity of access to needed care during service disruptions.</p>	<p>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.</p> <p>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).</p> <p>Continuity of the health department's services or operation would <b>not</b> meet the intent of the requirement.</p> <p>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 <b>not</b> meet the intent of this requirement.</p> <p>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.</p> <p><b>Documentation Examples</b>            Documentation could include, 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.</p>		

## 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** **8.1.1 A:** Recruit and promote the development of a qualified and diverse public health workforce.

**8.2.1 A:** Develop and implement a workforce development plan and strategies.

## STANDARD 8.1

# Encourage the development and recruitment of qualified public health workers.

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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 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Recruit and promote the development of a qualified and diverse public health workforce.

**Purpose & Significance**

The purpose of this measure is to assess the health department's efforts to recruit and hire a qualified and diverse workforce and to build the pipeline for future public health workers. Health departments' success, as in all organizations, depends on the capabilities and performance of its staff. Recruitment 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. Collaborations with community groups and academic institutions can support both the recruitment for specific positions and the development of the public health workforce of the future.

MEASURE 8.1.1 A: Required Documentation 1	Guidance	Number of Examples Narrative description	Dated Within Current process
<p>1. Efforts aimed at securing a qualified and diverse workforce, which must include efforts the health department has taken to:</p> <p>a. Consider diversity, equity, or inclusion in recruitment <b>and</b> hiring efforts.</p>	<p>The intent of this requirement is to describe the health department's efforts to recruit <b>and</b> hire a qualified and diverse workforce, both by helping to build the pipeline for future workers and in its specific efforts to recruit and hire employees. The narrative will describe efforts, which may include successes or failures. It could discuss how the health department works with its human resources department in successful or unsuccessful efforts to secure a qualified and diverse workforce.</p> <p>Describing use of EEO statements in job posting or EEO policies alone, does <b>not, on its own</b>, meet the intent of the requirement.</p> <p>Tribal health departments may describe their use of Indian Preference hiring policies.</p> <p><b>For required element a:</b> The methods for recruitment could 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 related to positions aimed at addressing the root causes of health inequities or social determinants of health.</p> <p>A workforce could be diverse as it relates to, for example, race/ethnicity, culture, language, age, gender, or 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.</p> <p>When HR functions are outside the health department, the description could include how the health department, for example, provides suggestions to HR on a recruitment or hiring policy, reviews qualifications listed in a job description, provides suggestions on the dissemination of job openings, or works with HR to establish systems or processes that consider workforce diversity.</p>		

<b>MEASURE 8.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current process
<p>b. Collaborate with other organizations to recruit for health department positions.</p> <p>c. Collaborate with other organizations to build the pipeline of public health workers.</p>	<p><b>For required element b:</b>            The description about collaborative recruitment for health department positions could include, for example, working with community partners or agencies as part of recruitment efforts geared towards those with lived experiences, such as people in recovery (substance use program areas) or breastfeeding mothers (peer counselors, MCH). Health department staff may also be able to leverage their relationships with community members to recruit for positions (i.e., if staff are engaging with veterans or residents of a particular religious or cultural community, they may be able spread the word about job openings).</p> <p><b>For required element c:</b>            The description will describe efforts to build the pipeline for future workers. Working with youth organizations, libraries, community groups, elementary or high schools, schools or programs of public health, or other related academic and educational programs (e.g., 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) is a means to promote public health as an attractive career choice. Promoting public health as a career choice could be accomplished 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, health department participation in a career fair, or development or maintenance of an Academic Health Department.</p>		

## **STANDARD 8.2**

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

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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 and implement a workforce development plan and strategies.

**Purpose & Significance**

The purpose of this measure is to assess the health department's development and implementation of a 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, as well as efforts to support management and leadership skills. 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 armed 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. Professional development activities can assist current and future health department leaders to employ state-of-the-art techniques to lead people and organizations.

MEASURE 8.2.1 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
<p>1. A health department-specific workforce development plan that includes:</p> <p>a. A description of the current capacity of the health department both as a whole and within its sub-units.</p> <p>b. An organization-wide assessment of current staff capabilities against an accepted set of core competencies.</p>	<p>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.</p> <p><b>For required element a:</b> 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 <b>not</b> 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 <b>not</b> 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.</p> <p><b>For required element b:</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.</p>		

<b>MEASURE 8.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>c. Findings from an equity assessment that considers staff competence in the areas of cultural humility, diversity, or inclusion.</p> <p>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.</p> <p>e. Plans to address at a minimum two of the gaps in required element d; for each gap, documentation must include:</p> <p>i. Measurable objectives.</p> <p>ii. Improvement strategies or activities with timeframes.</p>	<p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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.</p> <p><b>For required element e:</b> 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.</p> <p>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.</p>		

<b>MEASURE 8.2.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> 5 years
2. Impact of implementing the workforce development plan.	The intent of this requirement is to describe outcomes from implementing the workforce development plan. The description could include successful or unsuccessful implementation, including what was learned based on the implementation. It could describe, for example, how efforts to address workforce capacity and capabilities have translated into improved organizational operations (e.g., improved employee satisfaction or increased the ability of the health department to administer contracts, apply for grants, or communicate effectively). The outcomes could also relate to interventions in the community or how communities are being served (e.g., enhancing the ability of the health department to work with populations of higher risk, or strengthening health promotion activities in the community).		
<b>MEASURE 8.2.1 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Current process
3. The process for developing management or leadership skills as part of succession planning.	The intent of this requirement is to describe efforts to develop future managers or leaders. The process could include policies or processes that provide a continuum of support for the future workforce. The health department could describe, for example, opportunities for staff to build leadership or management skills by being responsible for tasks of increasing complexity; rotating through other positions or serving in those positions in an interim or acting basis; or conducting assessments of management skills (e.g., 360 degree evaluations where staff are assessed by their peers, the individuals they supervise, and those they report to) and providing coaching where appropriate. The process could also describe deliberate efforts to strengthen skills that 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, and leading teams and collaborations. The process could also describe training and development opportunities offered to staff, such as, executive management seminars or programs, graduate programs in leadership or management, or participation in national or state-based leadership institutes.		

## MEASURE 8.2.2 A:

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# 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.

<b>MEASURE 8.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 policy or set of policies</b>	<b>Dated Within 5 years</b>
<p>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:</p> <p>a. Employee wellness.</p> <p>b. Work-life balance.</p> <p>c. Employee recognition.</p> <p>d. Inclusive culture.</p>	<p>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 <b>not</b> be appropriate.</p> <p><b>For required element a:</b> 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).</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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.</p>		

<b>MEASURE 8.2.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>2. Efforts taken to improve the work environment or improve employee satisfaction.</p> <p>At least one example must demonstrate taking action as a result of staff feedback or worker satisfaction assessment.</p>	<p>Examples could address improvement efforts in areas including, for example, work-life balance, employee recognition, employee wellness, or staff inclusion.</p> <p>Efforts could include, for example, completed QI projects, revised policies or procedures, staff events, new or revised communication methods from leadership, or other activities to build a supportive workplace.</p> <p>At least one example will be based on the results of a staff assessment, which could be through a formal mechanism (e.g., a staff-wide survey) or an informal one (e.g., an employee suggestion box).</p> <p>The second example could also be based on employee feedback or could demonstrate improvement efforts identified through other methods, such as the regular review and updating of supportive workplace policies or analysis of retention rates.</p> <p>In a centralized state, the state health department could include examples related to staff serving local jurisdictions.</p>		

## MEASURE 8.2.3 S:

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# Support efforts of Tribal and local health departments to strengthen the public health workforce.

### **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.

<b>MEASURE 8.2.3 S:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Support provided to multiple Tribal <b>and</b> local health departments to be responsive to their needs regarding strengthening the workforce.</p> <p>If there is at least one Tribal health department in the state, then the example must include support to both Tribal <b>and</b> local health department(s).</p>	<p>The intent of this requirement is that support is provided to multiple health departments based on their needs to bolster their workforce, rather than a one time or one-way communication. A broad workforce development effort not focused on meeting the needs of Tribal or local health departments—for example, a collaboration with a school of public health to promote public health careers, in general—would <b>not</b> meet the intent of the requirement, unless the example included coordination with multiple Tribal or local health departments or efforts to facilitate placements with Tribal or local health departments. Similarly, an effort to work directly with just one health department would <b>not</b> meet the intent.</p> <p>Support provided to Tribal and local health departments could include, for example,</p> <ul style="list-style-type: none"> <li>• Funding provided to multiple health departments across the state to support workforce capacity building, learning activities, professional development activities, or other resources (e.g., access to learning management systems).</li> <li>• Developing a leadership program open to health departments across the state.</li> <li>• Working collaboratively with schools of public health or other academic institutions to develop resources for use by Tribal and local health departments related to recruitment, retention, or succession planning.</li> <li>• Conducting workforce assessments and using results for collective problem-solving to address gaps in workforce capacity or capabilities among multiple Tribal and local health departments (e.g., convening a group of health departments to work collectively on assessing and meeting workforce demands).</li> <li>• Convening a learning community to enable health departments to learn from each other about workforce development strategies.</li> </ul> <p>The state health department <b>cannot</b> 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 Tribal health departments and local jurisdictions.</p> <p>The state health department may not be able to meet all the needs of Tribal or local 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.</p> <p>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. For example, the Documentation Form could describe how the results of an assessment were used to collectively problem-solve a gap or could describe a less formal approach to understand needs, such as, through conversations, or meetings (e.g., Council or Nations leadership meetings).</p>		

## 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

<b>Standard 9.1:</b>	Build and foster a culture of quality.
<b>Standard 9.2:</b>	Use and contribute to developing research, evidence, practice-based insights, and other forms of information for decision making.

### FOUNDATIONAL CAPABILITY MEASURES:

<b>Accountability &amp; Performance Management</b>	<b>9.1.1 A:</b>	Implement the performance management system.
	<b>9.1.3 A:</b>	Implement quality improvement projects.
	<b>9.2.1 A:</b>	Base programs and interventions on the best available evidence.

## **STANDARD 9.1**

### **Build and foster a culture of quality.**

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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

# 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 identifying and managing opportunities for improvement. 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, to demonstrate the work of the health department and public health system to improve 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 the need to improve organizational results.

<b>MEASURE 9.1.1 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 performance management system	<b>Dated Within</b> 5 years
<p>1. A department-wide performance management system, which includes:</p>	<p>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 <b>not</b> 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.</p> <p>Performance could be managed in, for example, a software program purchased or developed by the health department, an Excel workbook, or other mechanism.</p> <p>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.</p> <p>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.</p> <p>The health department could include data from, for example:</p> <ul style="list-style-type: none"> <li>• State-based information systems to determine if it is meeting performance goals established through state program requirements.</li> <li>• Surveillance systems to determine if it is meeting performance goals associated with the timeliness of disease investigation or reporting.</li> <li>• Internal data systems for collecting progress updates from staff responsible for strategic plan objectives.</li> </ul>		

<b>MEASURE 9.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 performance management system</b>	<b>Dated Within 5 years</b>
<p>a. Performance management goals <b>and</b> the associated objectives with time-framed and measurable targets.</p> <p>b. A description of how the performance management system operates, including the process for how staff will:</p>	<p><b>For required element a:</b> 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.</p> <p>The health department could, for example, set their performance objectives based on a combination of the following:</p> <ul style="list-style-type: none"> <li>• National, state, or other scientific guidelines (e.g., Healthy People 2030, state program requirements, or accreditation standards and measures).</li> <li>• Funders' performance or reporting requirements (e.g., outlined in grant requirements).</li> <li>• Benchmarks derived from peer organizations (e.g., neighboring health departments or health departments of similar size/characteristics).</li> <li>• Expectations of the public or leadership (e.g., public health performance objectives set by the governing entity).</li> <li>• 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).</li> </ul> <p>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 <b>not</b> need to show every goal and objective, but will reflect the breadth of the goals and objectives included in the performance management system.</p> <p><b>For required element b:</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:</p>		

<b>MEASURE 9.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 performance management system</b>	<b>Dated Within 5 years</b>
<p>i. Enter data in the performance management system.</p> <p>ii. Monitor data on performance.</p> <p>iii. Communicate results on a regular reporting cycle.</p> <p>iv. Use data to guide decision-making.</p> <p>v. Use data to facilitate continuous quality improvement.</p> <p>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.)</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>For required element c:</b> Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities. The performance management system does <b>not</b> 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 <b>not</b> 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.</p>		

<b>MEASURE 9.1.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
2. Implementation of the performance management system. The example must include customer feedback.	<p>The documentation could address successes or unsuccessful implementation, including what was learned based on the implementation of the performance management system. It could describe, for example, how performance data were used to inform a health department decision that had positive effects on the department or community, or how monitoring the performance management data led to the implementation of quality improvement processes. In the context of this requirement, “customer” refers to the group impacted by the performance management goal. In this sense, customers could refer to partners or key stakeholders or, if it’s an administrative goal, the customers could be internal to the health department. The example could be tied to the quality improvement project (required within 9.1.3 A) or highlight another story of using customer feedback as part of performance management system implementation.</p>		

**MEASURE 9.1.2 A:**

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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.

<b>MEASURE 9.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>1. A quality improvement (QI) plan that addresses each of the following:</p> <p>a. List and description of key quality terms.</p> <p>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.</p> <p>c. Description of QI learning opportunities offered to all levels of department staff.</p> <p>d. Description of the process for identifying, prioritizing, <b>and</b> initiating QI projects.</p>	<p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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.</p>		

<b>MEASURE 9.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 plan</b>	<b>Dated Within 5 years</b>
<p>e. Goals and objectives with time-framed targets, related to the department's QI plan implementation.</p> <p>f. Description of how implementation of the QI plan is monitored.</p> <p>g. Communication strategies used to share with stakeholders about QI activities conducted by the health department.</p>	<p><b>For required element e:</b> 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 <b>not</b> meet the intent of this requirement.</p> <p>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.</p> <p><b>For required element f:</b> 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.</p> <p><b>For required element g:</b> 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.</p> <p>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.</p>		

**MEASURE 9.1.3 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.

<b>MEASURE 9.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>1. Implementation of quality improvement (QI) projects that demonstrate the following:</p> <p>a. How the opportunity for improvement was identified.</p> <p>b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement.</p>	<p>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 <b>not</b> 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 <b>not</b> be sufficient to meet the intent of this requirement.</p> <p>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.</p> <p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p>		

<b>MEASURE 9.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>c. Use of a QI method.</p> <p>d. Use of QI tools to better understand or make decisions about:</p> <p>i. The current process.</p> <p>ii. Root cause(s).</p> <p>iii. Possible solutions.</p> <p>iv. Prioritization/selection of solutions for implementation.</p>	<p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> QI tools appropriate for a given improvement model will vary based on the method selected and the type or problem identified.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

<b>MEASURE 9.1.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>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.</p>	<p><b>For required element e:</b> 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.</p> <p>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.</p> <p><b>Documentation Examples</b> 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.</p>		

**MEASURE 9.1.4 A:**

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# Nurture a culture of quality across the health department.

**Purpose & Significance**

The purpose of this measure is to assess the health department's ongoing efforts to build its quality improvement and performance management capacity and engrain continuous quality improvement into its culture. 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 department's units towards improving processes.

MEASURE 9.1.4 A: Required Documentation 1	Guidance	Number of Examples Narrative description	Dated Within Describe the current process
<p>1. Maturity of performance management <b>and</b> quality improvement (QI) to foster a culture of quality, which includes:</p> <p>a. How performance management or QI have changed over time.</p> <p>b. How performance management or QI have been institutionalized.</p> <p>c. How performance management, QI, the community health improvement plan, <b>and</b> strategic plan are integrated.</p>	<p>The intent of the requirement is to address how the performance management system and QI at the health department have evolved over time. The narrative as a whole will address <b>both</b> QI and performance management, but required elements a, b, d, and e will focus on the components of performance management <b>or</b> QI that are most relevant to the health department's culture of quality.</p> <p><b>For required element a:</b> The intent of this required element is to describe how performance management or QI have evolved. Performance management systems could evolve based on the changing needs, priorities, and circumstances of the environment in which departments operate. Changes could include, for example, modifying, adding, or replacing performance goals or objectives; making changes to reporting processes or use of dashboards; adding health equity goals or objectives; or modifying processes to collect data from diverse perspectives of staff, partners, or community members. QI processes may have evolved based on implementation of the QI plan or QI projects or activities. This could include, for example, implementing additional projects, using additional QI methods or tools, or expanding QI activities among additional staff or areas of the health department. QI processes or examples could also have been adapted to consider prioritization for projects that will likely have the greatest impact on equity.</p> <p><b>For required element b:</b> The narrative could address, for example, progress identified based on a QI culture or performance management assessment (e.g., 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 Improvement) or other efforts to strengthen foundational elements (e.g., leadership commitment, QI infrastructure, employee empowerment, or customer focus).</p> <p><b>For required element c:</b> There will be a recognizable link between the health department's performance management system <b>and</b> the QI process(es) used within the department. The health department could, for example, use performance management data analyses to identify programs or processes appropriate for a QI project, determine where resources should be allocated or adjusted to improve efficiencies or effectiveness, or to identify an unmet community need. Linkages to the state/Tribal/community health improvement plan (CHIP) or strategic plan could include, for example, including in the performance management system objectives aligned to specific strategic planning or CHIP priorities or objectives.</p>		

<b>MEASURE 9.1.4 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe the current process
<p>d. How leadership is engaged in implementation of performance management or QI.</p> <p>e. How frontline or non-management staff are engaged in implementation of performance management or QI.</p>	<p><b>For required element d:</b> Describe how the health department director and other leadership foster a performance-based health department focused on supporting the implementation of department-wide performance management or QI. The narrative could describe, for example, leadership engagement in establishing or updating the system, contributing resources to support the performance infrastructure (e.g., hiring dedicated staff, enabling staff time for performance management or QI activities, providing learning and professional development opportunities for staff), or leadership's recognition of staff for contributions to performance management or QI.</p> <p><b>For required element e:</b> Engagement among frontline or non-management staff might include participation in, for example, the review or revision of the performance management system (e.g., goals, objectives, strategies, or targets); performance management system data collection, monitoring, or reporting; QI projects; efforts to assess the QI culture; or revision of the QI plan.</p>		

## STANDARD 9.2

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

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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

# Base programs and interventions on the best available evidence.

**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, as well as the use of evaluation to improve processes, programs, or interventions. 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, and interventions, as appropriate. Application of evidence and use of evaluation help assure that health department resources are being allocated and applied as effectively as possible.

<b>MEASURE 9.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Process (narrative description is acceptable)	<b>Dated Within</b> Current process
<p>1. Process for looking for evidence-based or promising practices when a program or intervention is developed or revised.</p>	<p>The intent of this requirement is for the health department to provide a process or description of how staff look for research- or practice-based programs, processes, and interventions that could be applied within their jurisdiction. A process could be demonstrated by providing a template or checklist.</p> <p>The process could also include, for example, the types of sources of research or practice-based information that are considered. 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. Some 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, other health departments, or other experts on a particular topic. Tribal health departments could select sources from the Indian Health Services (IHS) or other Tribal-specific sources.</p>		
<b>MEASURE 9.2.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Adoption of an evidence-based or promising practice that has been customized to be appropriate for the community and the community's particular characteristics.</p> <p>If the health department does not have an example within the timeframe, it will provide an example that has not been customized <b>and</b> a narrative describing the general process for tailoring evidence-based or promising practices to the communities served.</p>	<p>The documentation will include an example of customizing an evidence-based or promising practice to the community. The example could include how a small or rural health department used a practice-based intervention that was originally implemented in a large, urban community. 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.</p> <p>If the health department has not customized any evidence-based or promising practices during the timeframe, the health department will provide an example of an evidence-based or promising practice that was implemented without customization <b>and</b> a narrative describing the health department's general process for tailoring evidence-based or promising practices to the community. For example, the narrative of the process could describe the approach a small or rural health department generally uses to adapt a practice-based intervention to their jurisdiction. The description could also explain the process for adapting a research-based example of a health promotion effort designed for a specific cultural group to use for a different population group.</p>		

<b>MEASURE 9.2.1 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>3. Improvement made based on the evaluation of a program, process, or intervention.</p> <p>The health department must include a summary of the results of the evaluation.</p>	<p>The documentation or description will include a summary of the evaluation findings <b>and</b> resulting improvements to the program, process, or intervention. The data themselves used to inform the improvement are <b>not</b> required, but a summary of results will be provided.</p> <p>Quantitative or qualitative data could be used to evaluate a program, process, or intervention to determine if it is achieving its intended outcome and how it could be improved to better achieve that outcome. Evaluation findings might indicate whether the program, process or intervention is having an equitable impact on the population served and what changes could make the impact more equitable. Evaluations could be conducted by the health department or by other entities.</p> <p><b>Documentation Examples</b> Documentation could include, for example, improvements described within an evaluation report or presentation, program or project report submitted to a funding organization, or other summary of improvements to a program, process, or intervention based on an evaluation.</p>		

**MEASURE 9.2.2 A:**

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## 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.

<b>MEASURE 9.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Effort to foster innovation skills, practices, or processes.</p>	<p>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.</p> <p>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 <b>how</b> the health department has fostered innovation. Providing an example of a program that the health department considers innovative would <b>not</b> meet the intent, unless the example described the process by which the team came up with an innovative approach.</p> <p>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.)</p> <p><b>Documentation Examples</b> 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).</p>		

## MEASURE 9.2.3 T/S:

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# 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.

<b>MEASURE 9.2.3 T/S:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
1. Involvement with other researchers to foster research.	<p>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 <b>not</b> 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.</p> <p>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.</p> <p><b><u>Documentation Examples</u></b>            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.</p>		

## MEASURE 9.2.4 S:

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# 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 9.2.4 S: Required Documentation 1	Guidance	Number of Examples 1 example (narrative of an example is acceptable)	Dated Within 5 years
<p>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.</p> <p>If Tribal health departments are located within the state health department's jurisdiction, the example must reflect opportunities offered to <b>all</b> Tribes to provide their input on their needs.</p>	<p>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.</p> <p>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.</p> <p>The state health department <b>cannot</b> 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.</p> <p><b>Documentation Examples</b> 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.</p>		
MEASURE 9.2.4 S: Required Documentation 2	Guidance	Number of Examples 2 examples (narratives of examples are acceptable)	Dated Within 5 years
<p>2. Support provided to Tribal <b>and</b> local health departments to be responsive to their needs concerning the interpretation, adaptation, or application of relevant research or evidence-/practice-based learnings.</p>	<p>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.</p> <p>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.</p> <p>The state health department <b>cannot</b> 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.</p>		

<b>MEASURE 9.2.4 S: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>One example must be with a Tribal health department, if one exists in the state.</p> <p>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.</p>	<p>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 Tribal or local 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.</p> <p>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 <b>not</b> 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 <b>not</b> need to be.</p>		

## 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 department.

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

### DOMAIN 10 INCLUDES THREE STANDARDS

<b>Standard 10.1:</b>	Employ strategic planning skills.
<b>Standard 10.2:</b>	Manage financial, information management, and human resources effectively.
<b>Standard 10.3:</b>	Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision-making, and governance.

### FOUNDATIONAL CAPABILITY MEASURES:

<b>Organizational Competencies</b>	<b>10.1.1 A:</b>	Adopt a department-wide strategic plan.
	<b>10.2.2 A:</b>	Maintain a secure information management infrastructure to support strategic goals.
	<b>10.2.4 A:</b>	Oversee financial management systems.
	<b>10.3.2 A:</b>	Communicate with governance routinely and on an as-needed basis.
	<b>10.3.3 A:</b>	Access and use legal services in planning, implementing, and enforcing, public health initiatives.
<b>Equity</b>	<b>10.2.1 A:</b>	Manage operational policies including those related to equity.

## STANDARD 10.1

### Employ strategic planning skills.

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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:**

## 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.

<b>MEASURE 10.1.1: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> 5 years
<p>1. The process to develop the strategic plan, which includes:</p> <p>a. How the health department's staff at various levels <b>and</b> the governing entity or advisory board are engaged in developing the strategic plan.</p> <p>b. Strategic planning process steps.</p>	<p><b>For required element a:</b> Engaging staff at all levels (e.g., both leadership or management and non-managerial or frontline staff) <b>and</b> a representative(s) of the governing entity (e.g., member of the board of health or representative from the governor's or mayor's office) or advisory board fosters transparency and shared ownership of the health department's strategic plan and priorities. 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 or developing elements of the strategic plan, such as, the mission, vision, values, or strategic priorities. While the health department does <b>not</b> need to engage the governing entity or staff in every strategic planning meeting, the intent is that the governing entity <b>and</b> staff provide input during the development process to inform the final version.</p> <p><b>For required element b:</b> Steps in the planning process could include, for example, stakeholder analysis; strengths, weaknesses, opportunities, and threats (SWOT) or strengths aspirations, opportunities, and results (SOAR) analysis; scenario development; a workforce or technology assessment, or prioritization process.</p>		
<b>MEASURE 10.1.1: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 strategic plan	<b>Dated Within</b> 5 years
<p>2. A department-wide strategic plan, which must include:</p> <p>a. The health department's mission, vision, <b>and</b> guiding principles or values.</p>	<p>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.</p> <p>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.</p> <p><b>For required element a:</b> 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.</p>		

<b>MEASURE 10.1.1:</b> <b>Required</b> <b>Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 strategic plan	<b>Dated Within</b> 5 years
<p>b. Strategic priorities.</p> <p>c. Objectives with measurable and time-framed targets.</p> <p>d. Strategies or actions to address objectives.</p> <p>e. A description of how the strategic plan's implementation is monitored, including progress towards achieving objectives, and strategies or actions.</p> <p>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.)</p>	<p><b>For required element b:</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).</p> <p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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.</p> <p><b>For required element e:</b> 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.</p> <p><b>For required element f:</b> 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.</p>		

<b>MEASURE 10.1.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 strategic plan	<b>Dated Within</b> 5 years
<p>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.)</p> <p>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.</p>	<p><b>For required element g:</b> 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.</p> <p>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).</p>		

**MEASURE 10.1.2 A:**

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# 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.

<b>MEASURE 10.1.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples	<b>Dated Within</b> 3 years (2 most recent reports)
<p>1. Monitoring of progress towards <b>all</b> the strategic plan objectives.</p> <p>Reviews must be completed at least annually.</p> <p>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.</p>	<p>The intent of this requirement is to show monitoring of progress towards <b>all</b> objectives within the strategic plan. A review of one or a few objectives would <b>not</b> 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).</p> <p>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.</p> <p><b>Documentation Examples</b> Documentation could include, for example, progress reports or presentations, or screenshots of a dashboard showing actual progress towards objectives.</p>		
<b>MEASURE 10.1.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 2 years
<p>2. Communication with governance <b>and</b> staff at various levels concerning implementation of the strategic plan.</p> <p>One example must demonstrate sharing with staff and one example must demonstrate sharing with the governing entity or advisory board.</p>	<p>The intent of this requirement is that the health department informs at least one of its governing entities or advisory boards <b>and</b> 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.</p> <p>In a centralized state, the state health department could include staff serving local jurisdictions, as appropriate.</p> <p><b>Documentation Examples</b> Documentation could include, for example, meeting minutes, reports shared with the governing entity and staff, presentations, emails, or other discussion records.</p>		

## STANDARD 10.2

### Manage financial, information management, and human resources effectively.

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Sound financial, information management, and human resource practices are fundamental to any organization. A strong infrastructure depends on the health department's ability to manage resources wisely, to analyze present and future needs, to sustain operations, and demonstrate accountability. This standard assesses the capacity of the health department to establish and maintain budgeting, auditing, billing, and financial systems, and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies.

This standard also includes the health department's capacity for securing and managing grants; demonstrating financial flexibility during uncertain or unplanned events; and meeting generally accepted audit requirements based on the source of funds utilized for service provision.

**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.

<b>MEASURE 10.2.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe current process
<p>1. Operational policies or procedures, <b>including</b> human resource policies or procedures, are reviewed and revised on a routine basis. The narrative must include:</p> <p>a. The process <b>and</b> frequency of review and revision.</p> <p>b. How the department addresses changing or emerging administrative or management considerations.</p> <p>c. How changes are communicated to staff.</p> <p>In centralized states, state health departments must describe how changes that apply to staff serving local jurisdictions are communicated to those staff.</p>	<p>Operational policies are intended to direct the operations of the health department as a whole. Program policies would <b>not</b> meet the intent of this requirement.</p> <p>If the health departments uses government-wide (i.e., Tribal, state, city, or county) or super health agency or umbrella agency policies or procedures, the description could address how the health department reviews and provides input on suggested changes to the agency.</p> <p><b>For required element a:</b> The description could include, for example, the schedule for how often policies and procedures are reviewed, how the health department keeps track of when polices or procedures are due for review, who is involved in the review and revision process, and how revisions are finalized or adopted.</p> <p><b>For required element b:</b> Changing or emerging considerations could be related to, for example, legislative changes (e.g., updates to the IRS' mileage reimbursement rates or labor laws), modified policies or procedures about the use of technology (e.g., telework policies), organizational restructuring, workforce diversity, change management, or leadership development practices. The description could address, for example, how considerations are raised and what process steps occur to address such considerations within operational policies or procedures.</p> <p><b>For required element c:</b> Methods to communicate changes to staff could include, for example, memos or emails to staff with revised policies and procedures attached or with the location of electronic or hard copy versions.</p>		

<b>MEASURE 10.2.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 list of terms with definitions	<b>Dated Within</b> 5 years
2. Adopted definitions of equity terms.	<p>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.</p> <p>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.</p> <p>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.</p>		
<b>MEASURE 10.2.1 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
3. Department-wide policy, declaration, or initiative that reflects specific intention focused on inclusion, diversity, equity, or anti-racism.	<p>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 <b>not</b> meet the intent.</p> <p>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.</p> <p>While the definitions from Required Documentation 2 could be part of this example, the definitions alone would <b>not</b> meet the intent of this requirement.</p>		

**MEASURE 10.2.2 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Maintain a secure information management infrastructure to support strategic goals.

**Purpose & Significance**

The purpose of this measure is to assess how the health department protects the security of its data systems and confidential information from risks and potential threats, as well as ways the health department has leveraged its information management systems to advance strategic goals. Use of information management systems can be a powerful tool to support efficient and effective programs and operations, as well as the flow of 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. Health departments should maintain protections for safe storage, handling, and access to classified, confidential, and sensitive information (e.g., client records, surveillance data, and human subjects research sensitive information).

<b>MEASURE 10.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 policy or set of policies	<b>Dated Within</b> 5 years
<p>1. A department-wide information security policy that includes the following:</p> <p>a. A description of the requirements for password complexity <b>and</b> lifespan.</p> <p>b. A process for ensuring physical security of information <b>and</b> network security.</p> <p>c. A policy for data that require additional privacy protection, which includes:</p>	<p>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 <b>not</b> confidentiality of employee records.</p> <p>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.</p> <p><b>For required element a:</b> 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.</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p>		

<b>MEASURE 10.2.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 policy or set of policies	<b>Dated Within</b> 5 years
<p>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.</p> <p>ii. A process for user access management for electronic data and data systems.</p> <p>iii. A process for maintaining confidentiality of data that are stored as paper versions, as appropriate.</p>	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> <p>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.</p> <p>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.</p>		
<b>MEASURE 10.2.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Improvement to information management systems to advance strategic goals.</p>	<p>Advancing strategic goals could relate to, for example, the health department's mission or strategic plan, or the state/Tribal/community health improvement plan. The example could directly tie to achieving goals, such as:</p> <ul style="list-style-type: none"> <li>• If a strategic plan priority is to expand the community's awareness of the health department, the health department could redesign the health department's website or social media capabilities;</li> <li>• If a strategic plan priority is to maintain a productive workforce and replacing technology has been identified as an important component for recruiting and retaining talented workers; or</li> </ul>		

<b>MEASURE 10.2.2 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
	<ul style="list-style-type: none"> <li>If a state/Tribal/community health improvement plan priority relates to reducing foodborne illness, the health department could improve the information systems that are used to monitor restaurant inspections.</li> </ul> <p>Examples could also broadly address how information management has supported monitoring implementation of strategic plan or community health improvement goals, for example, designing and implementing an information management system for reporting in order to foster awareness of strategic goals and transparency about progress towards meeting them infrastructure to foster awareness of strategic goals, transparency of progress.</p>		

## MEASURE 10.2.3 A:

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# Ensure facilities are accessible.

### **Purpose & Significance**

The purpose of this measure is to assess the accessibility of services when they are provided offsite or in a temporary location. In order for the health department to implement processes, programs, and interventions, the facilities must consider accessibility, especially among those with disabilities for greater ease of access and safety.

<b>MEASURE 10.2.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>1. Assurance of accessibility to health department's facilities or services when services are provided offsite or in a temporary location.</p> <p>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 <b>no</b> documentation is needed for this requirement.</p>	<p>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.</p> <p>This requirement does <b>not</b> 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).</p> <p>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.</p> <p>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.</p>		

**MEASURE 10.2.4 A:**

## FOUNDATIONAL CAPABILITY MEASURE

# Oversee financial management systems.

**Purpose & Significance**

The purpose of this measure is to assess the health department's accountable financial stewardship and oversight of agreements with other organizations, as well as its audit process. This includes the health department's ability to improve its processes for complying with requirements for funds provided through grants and contracts, as well as the health departments' monitoring of organizations that provide services, programs, or interventions on behalf of the health department. It is important that funds are used appropriately and legitimately, and that the health department has systems for accountability. Preventing or addressing audit findings or findings related to being a high-risk grantee are other important components of accountability.

<b>MEASURE 10.2.4 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> All, as appropriate	<b>Dated Within</b> 5 years
<p>1. <b>All</b> formal communications from state or federal funders that indicate the health department is a “high-risk grantee.”</p> <p>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 placed on provisional status; placement on a ‘do not fund’ list; receivership status; and instances of malfeasance or misappropriations of funds.</p> <p>Documentation must include a description of follow-up actions or internal controls in place to facilitate resolution of the situation.</p>	<p>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.</p>		

<b>MEASURE 10.2.4 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> All, as appropriate	<b>Dated Within</b> 5 years
<p>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.</p>	<p>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 <b>not</b> necessary to describe follow-up actions).</p>		
<b>MEASURE 10.2.4 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Improvement made to the health department’s processes for managing written agreements with other organizations or for demonstrating compliance with requirements from its funders.</p>	<p>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).</p> <p>Improvements do <b>not</b> 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.</p> <p><b>Documentation Examples</b> Documentation could include, for example, improvements discussed during a meeting or summarized in a report or quality improvement project.</p>		

MEASURE 10.2.4 A: Required Documentation 3	Guidance	Number of Examples 2 examples	Dated Within 5 years (two most recent audits)
<p>3. External department-wide financial audit reports.</p> <p>The audits must be full health department audits (<b>not</b> single program audits).</p>	<p>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.</p> <p><b>Documentation Examples</b> 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.</p>		
MEASURE 10.2.4 A: Required Documentation 4	Guidance	Number of Examples 1 example (narrative of an example is acceptable)	Dated Within 3 years
<p>4. Improvement steps identified based on findings from the most recent audit.</p> <p>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 <b>no</b> documentation is needed for this requirement.</p>	<p>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 <b>not</b> necessary for those steps to have been completed by the time the documentation is submitted.</p> <p>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.</p>		

## MEASURE 10.2.5 A:

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# 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 maintain financial sustainability to support its infrastructure or to sustain, enhance, or develop programs and interventions. It is important 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. Financial resources should be maximized by leveraging current funds to increase resources available for public health.

<b>MEASURE 10.2.5 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable)	<b>Dated Within</b> 5 years
<p>1. Efforts to ensure the health department's sustainability.</p> <p>One example must be an effort to evaluate financials and the other must be an effort to seek additional financial resources or increase efficiencies.</p> <p>At least one example must show engagement with the governing entity that has financial oversight for the health department.</p>	<p>The intent of this requirement is that the health department regularly applies a business approach to support its financial infrastructure, which includes both evaluation of financials and seeking additional funding or improving financial sustainability by increasing efficiencies.</p> <p>Evaluation of financials through a business lens could include, for example, examining performance-based budgeting or Return on Investment (ROI) of services, considering concepts of public health economics (e.g., supply/demand factors in consideration of other service providers within the health department's jurisdiction or competitor analysis), or establishing a business plan or strategic financial plan (e.g., capitol or marketing plans).</p> <p>Efforts to seek additional financial resources could include, for example, budget increase requests, budget revision requests, or grants. Examples could also address efforts to sustain 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 example of an effort to seek additional financial resources may include successful or unsuccessful efforts the health department has taken.</p> <p>Engagement with the governing entity could include, for example, requesting funding from that entity; having the governing entity, in conjunction with the health department, communicate with others about the need for additional financial resources for the health department; or communicating to the governing entity about the evaluation of the financials and needs. 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).</p>		

<b>MEASURE 10.2.5 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 process	<b>Dated Within</b> 5 years
<p>2. The process for flexible financial management during uncertain or unplanned events. The process must address:</p> <p>a. How the approval process will be expedited for rapid program development, execution, or program revision to address unanticipated challenges or opportunities.</p> <p>b. How resources will be allocated in response to an unplanned event through a health equity lens or in consideration of populations with higher health risks.</p> <p>c. How the approval process for written agreements with other entities will be expedited.</p>	<p>The health department will provide a process for how it adapts its standard procedures to manage uncertainty or unplanned events. The process could be outlined as an approach, policy, or procedure that considers prioritizing maintenance of essential services during uncertain times or events (e.g., a public health emergency or severe budget cuts). The intent of this requirement is that the process serve as a guide to outline how decisions will be made and how essential services will be resourced to sustain critical operations. The process could also describe how the health department adapts to new opportunities, for example, the creation of a new source of funding for health in the community.</p> <p>The health department 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.</p> <p><b>For required element a:</b> The process could outline how the health department is able to bypass normal processes to create new, or revise existing, programs, if warranted under a given situation.</p> <p><b>For required element b:</b> The process could include, for example, how subpopulations or groups will be identified and resources mobilized to address disparities and those disproportionately affected by unplanned events.</p> <p><b>For required element c:</b> The process could address, for example, expediting agreements with other governmental entities or organizations (e.g., through intergovernmental disaster response coordination or other agreements, such as MOUs/MAAs in place in the event of an emergency).</p>		
<b>MEASURE 10.2.5 A: Required Documentation 3</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>3. Implementation of flexible financial management strategies or initiatives for uncertain or unplanned events (based on the process described in Required Documentation 2).</p>	<p>The example could reflect executed agreements with other agencies (e.g., contracts, MOUs/MAAs) for contingency use in the event of uncertainty or an unplanned event (e.g., equipment, locations, or personnel) or implementation of the process to expedite rapid program development by by-passing standard approval processes. The example could also pertain to new opportunities.</p>		

## STANDARD 10.3

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

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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:**

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## 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.

<b>MEASURE 10.3.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 process	<b>Dated Within</b> 5 years
<p>1. A process describing how ethical issues are deliberated <b>and</b> resolved.</p> <p>The process must describe:</p> <p>a. Which individuals are responsible for making collaborative decisions about ethical issues.</p> <p>b. How the decisionmakers gather information, including input from affected stakeholders.</p> <p>c. How the decision could be re-evaluated in light of new information.</p> <p>d. How the decision is communicated back to affected stakeholders.</p>	<p><b>For required element a:</b> 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).</p> <p><b>For required element b:</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.</p> <p><b>For required element c:</b> 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.</p> <p><b>For required element d:</b> 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).</p>		

<b>MEASURE 10.3.1 A:</b> <b>Required</b> <b>Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Resolution or prevention of the occurrence of an ethical issue using the process provided in Required Documentation 1.</p> <p>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.</p>	<p>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.</p> <p>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 scarce 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).</p> <p>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.</p> <p><b>Documentation Examples</b>            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.</p>		

**MEASURE 10.3.2 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.

<b>MEASURE 10.3.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe the current working relationship
<p>1. Working relationship between the health department and its governing entity(ies) and advisory boards. The narrative must include:</p> <p>a. A description of the methods <b>and</b> frequency of regular communications between the health department and its governing entity and advisory board. If the health department has multiple governing entities or mandated advisory boards, the description must address each.</p> <p>b. A description of how the health department communicates with its governing entity or advisory board outside of its regular communications.</p>	<p>The intent of this requirement is to describe the working relationship between the health department and its governing entity(ies) and advisory board(s). If a health department has multiple governing and advisory entities (e.g., one for advisory purposes and another that sets policy), the narrative will reflect the methods and frequency of communication for each entity (required element a). For required elements b-d, the health department can select which entity(ies) to describe.</p> <p><b>For required element a:</b> Methods could include, for example, meetings or correspondence (e.g., email updates, newsletters specific to the governing entity, or reports developed for the governing entity). Frequency could include, for example, the regular schedule of meetings or frequency of regular written communications.</p> <p><b>For required element b:</b> The intent of this required element is that communication with governance be transparent and flexible enough to expand beyond the established frequency or traditional methods if needed. For example, communications could be to inform the governing entity about important legislative or policy changes and their implications on public health practice or the health department. Other examples could include, for example, 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 communication 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.</p>		

<b>MEASURE 10.3.2 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> Narrative description	<b>Dated Within</b> Describe the current working relationship
<p>c. A description of how the health department ensures that the governing entity or advisory board has accurate <b>and</b> relevant information to inform its decision making.</p> <p>d. A description of how the health department shares information discussed by the governing entity or advisory board with all levels of health department staff.</p>	<p><b>For required element c:</b> The intent of this required element is that the health department describe the process for providing accurate (i.e., science-based, utilizing the most current data available) and relevant (i.e., applicable to the community served) information to inform the opinions, positions, and decisions of governance. Information shared could include, for example, routine information sharing on the health department's performance management system, strategic plan progress, state/Tribal/community health assessment findings, state/Tribal/community health improvement plan development and progress, workforce needs, and other operational and finance updates. This could also include keeping governance informed of emerging issues, current or proposed policies and their implications on public health, health indicators, health equity and disparities, disease outbreaks, or environmental health hazards. The description could also include, for example, how the health department asks the governing entity about their information needs.</p> <p><b>For required element d:</b> The intent of this required element is to foster awareness among staff at all levels of the priorities, policy positions, opinions, and actions of governance. 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.</p> <p>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.</p>		

**MEASURE 10.3.3 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).

<b>MEASURE 10.3.3 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 2 examples (narratives of examples are acceptable) or 1 description of the process	<b>Dated Within</b> 5 years
<p>1. Engagement with legal counsel.</p> <p>At least one example must describe a situation where receiving <b>timely</b> legal counsel was important.</p> <p>If the health department has not consulted with legal counsel in the past 5 years, it must provide one description of the current process for requesting legal counsel.</p>	<p>The intent of this requirement is for the health department to demonstrate how it has consulted or otherwise engaged legal counsel.</p> <p>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.</p> <p>One of the examples will demonstrate how the health department attained timely legal counsel to allow for a response by a set deadline (e.g., a regulation that states the health department must respond to complaints within a set number of days).</p> <p><b>Documentation Examples</b> 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.</p>		







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# Standards & Measures for Reaccreditation, Version 2022

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