Standards & Measures for **Pathways Recognition**

Version 2022

PHAB

Adopted February 2022

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Version 2022

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INTRODUCTION

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

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

The Standards provide requirements and guidance for public health departments preparing for Pathways Recognition, reviewers that review and assess documentation submitted by applicant health departments, and for anyone offering consultation or technical assistance to health departments preparing for Pathways Recognition. **The Standards** also guide PHAB's Board of Directors and staff as they administer the Pathways Recognition Program.

Credibility in recognition results from consistent interpretation and application of defined standards and measures. **The Standards** set forth the domains, measures, and required documentation adopted by the PHAB Board of Directors in June 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 aid 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

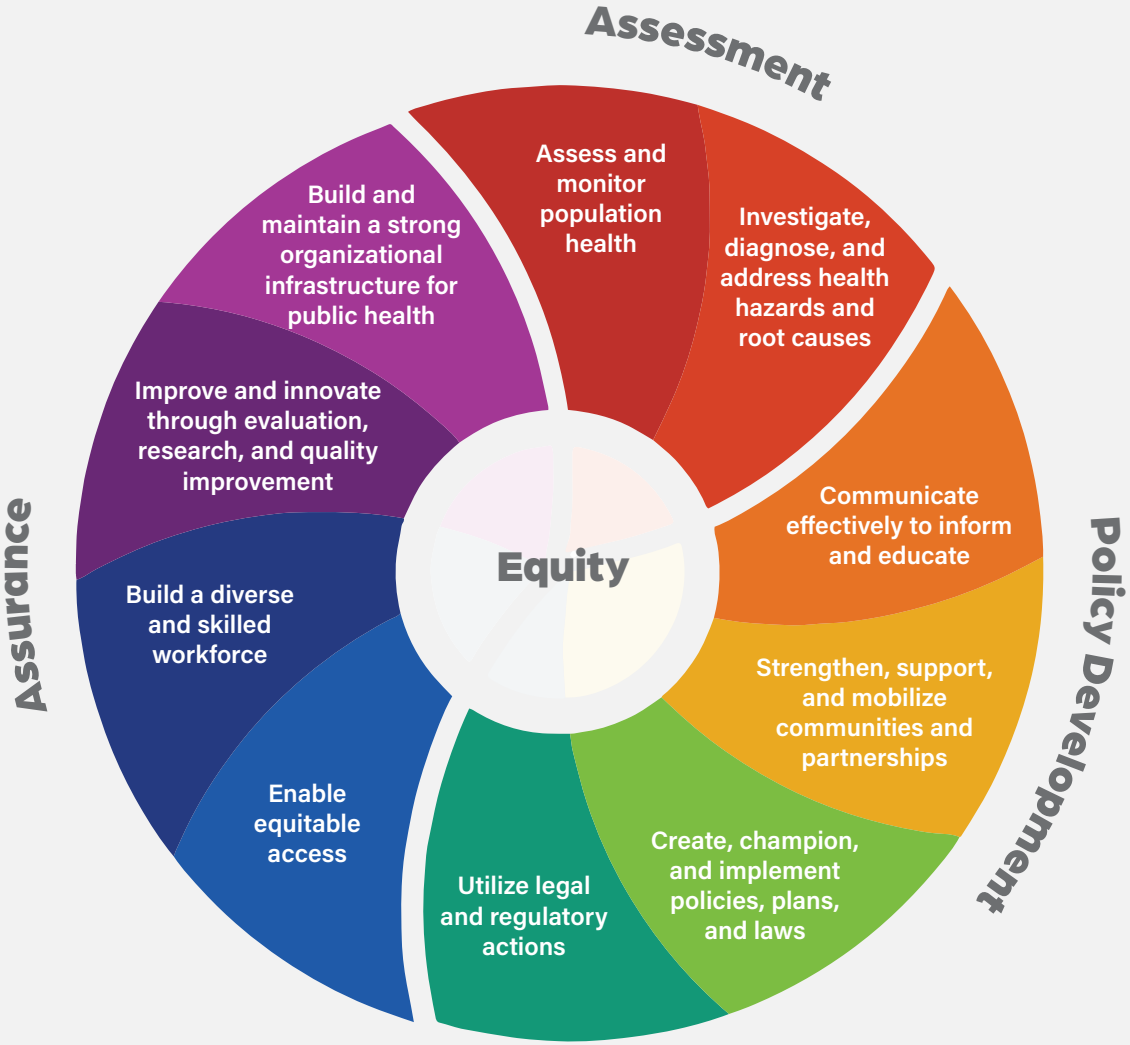
Domains are groups of standards that pertain to a broad group of public health services. This document does not include standards because initial accreditation standards include additional measures beyond what is required for Pathways Recognition.

There are 10 domains, aligned with the 10 Essential Public Health Services framework. **All of the measures are the same for Tribal, territorial and local health departments unless otherwise noted.**

The structural framework for the PHAB Pathways domains and measures uses the following taxonomy:	
Domain	Example – Domain 1
Measure	Example – Measure 1.2.2

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. **The 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. The PHAB Pathways Recognition Program is comprised of a subset of the requirements for initial accreditation and focus on some of the core 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.

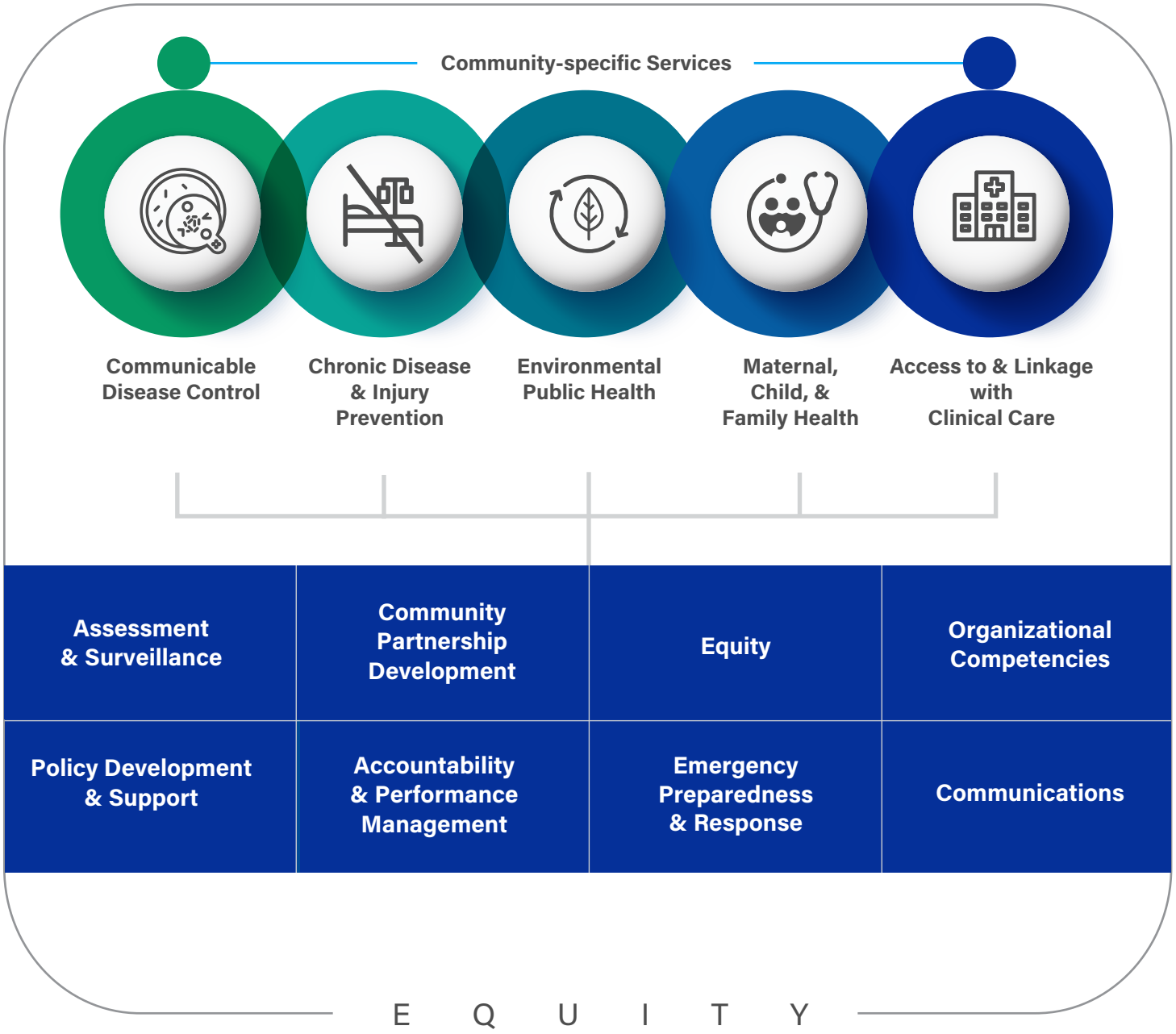
Foundational Capabilities, which provide the infrastructure needed to protect and provide fair and just opportunities for all, include: 1) Assessment & Surveillance, 2) Community Partnership Development, 3) Equity, 4) Organizational Competencies, 5) Policy Development & Support, 6) Accountability & Performance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

Pathways Recognition Program standards and measures are based on the Foundational Capabilities. Thus, Pathways Recognition gives reasonable assurance that public health infrastructure is in place for health departments that achieve Pathways Recognition.

The Pathways Recognition Program Measures have been divided into two tracks. Track 1 is Services and Partnerships; Track 2 is Health Department Systems.

Foundational Public Health Services

Foundational Areas



Foundational Capabilities

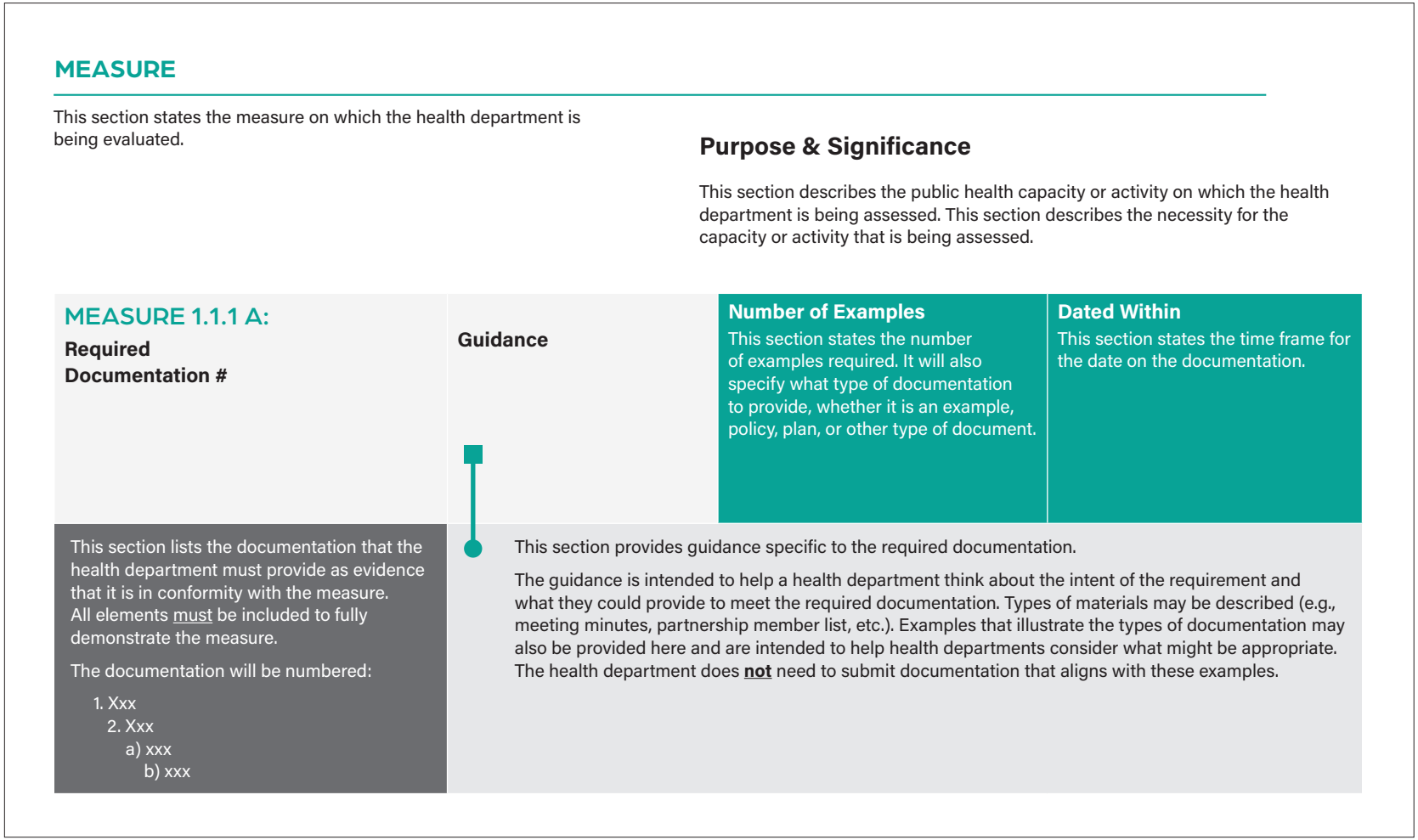
Assessment & Surveillance	Community Partnership Development	Equity	Organizational Competencies
Policy Development & Support	Accountability & Performance Management	Emergency Preparedness & Response	Communications

E Q U I T Y

PHAB

STRUCTURE OF THE REQUIREMENTS

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



REQUIREMENTS FOR ALL DOCUMENTATION

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

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

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

In addition:

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

Selection of Documentation

The health department should select documentation carefully to ensure that it accurately reflects the health department, how it operates, what it provides, and its performance. To ensure the Report, as prepared by the Review 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 Review Team. Additional examples, unless requested by the Review 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, and any measure reopened by the Review Team. 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 Review Team can easily identify evidence corresponding to the requirements. The Documentation Form should specify the specific part or section of document that addresses each required element in the measure, by referencing the **PDF page number** of the relevant part of the document. (The page number should represent which page in the PDF document; in other words, if the health department compiles excerpts from several different documents, the page number will indicate that it is the 5th page in the PDF, regardless of the page number on the original excerpt that has been merged into the PDF.)

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

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

Timeframes

All documentation used to demonstrate conformity with measures must be **dated** within the timeframe indicated in the "Dated Within" column. The date indicates when the document was created, adopted, reviewed, or revised. **The Review 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 Review Team to understand if the documentation is within the required timeframe, when assessing conformity.

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

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

Authorship and Evidence of Authenticity

The focus of **The Standards** is that the health department ensures that the services and activities are provided to the population, regardless of who provides the services and activities. The accountability for meeting

the measures rests with the health department being reviewed for accreditation. Unless **The Standards** indicate that required documentation is not applicable to a particular health department, documentation must be provided to demonstrate evidence of meeting the measure, even if the documentation is produced by another entity.

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

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

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

Examples include:

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

Likewise, the health department may be part of a "Super Public Health Agency," a "Super Health Agency," or "Umbrella Agency" (i.e., an agency that oversees public health and some combination of primary care, substance abuse, mental health, Medicaid, and other human service

programs). For example, the health department's human resource policy and procedures manual could be the manual of the Super Public Health Agency, Super Health Agency, or Umbrella Agency, of which it is a part. The functions associated with the 10 Essential Public Health Services may be contained in different divisions within the Umbrella Agency (i.e., a health department might have an environmental health division separate from the public health services division). In those cases, the applicant may use examples from any division of the Super Agency that carries out a public health function and falls within PHAB's Scope of Authority.

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

Requirements that are Not Applicable

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

- 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 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 Standards for Pathways Recognition address a subset of the public health functions and services in the 10 Essential Public Health Services.

- **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**).

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. Below are principles about what PHAB's accreditation **does not cover:**

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

TERMINOLOGY

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

Community

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

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

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

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

Governance

While **The Standards** do not assess the functioning of governing entities, there are requirements about the ways in which the health department interacts with those entities that play a public health governance role. Per the PHAB Glossary, "A governing entity is the individual, board, council, commission or other body with legal authority over the public health functions of a jurisdiction of local government; or region, or district

or reservation as established by state, territorial, or tribal constitution or statute, or by local charter, bylaw, or ordinance as authorized by state, territorial, tribal, constitution or statute." (National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf.) The health department may have multiple governing entities (e.g., city council, county commissioners) or entities that serve in an advisory role. For example, a health department's governing entity may be the board of health, but approval of ordinances or budgetary items may fall under the authority of a city council, county commissioners, or district advisory committee. In addition, a health department may be legally mandated to have one or more advisory boards to provide guidance on decision making about overall health department operations or public health in the jurisdiction. (Advisory boards that focus on a specific program area would not apply.) Because each of these entities plays a role in decision making that affects the health department and the population it serves, **The Standards** has requirements related to a variety of entities that play a governance role. The "Required Documentation" column will indicate which part of the health department's governance must be included in the documentation.

PUBLIC HEALTH SYSTEM CONSIDERATIONS

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.

All measures for PHAB initial accreditation are listed below. The measures highlighted in gray below are those assessed through the Pathways Recognition Program.

DOMAIN 1:

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

Measure 1.1.1:	**Develop a community health assessment.**
Measure 1.1.2:	Ensure the community health assessment is available and accessible to organizations and the general public.
Measure 1.2.1:	**Collect non-surveillance population health data.**
Measure 1.2.2 (Tribal and local health departments only):	**Participate in data sharing with other entities.**
Measure 1.2.2 (State health departments only):	Engage in data sharing and data exchange with other entities.
Measure 1.2.3 (State health departments only):	Facilitate use of statewide data systems.
Measure 1.3.1:	**Analyze data and draw public health conclusions.**
Measure 1.3.2:	Share and review public health findings with stakeholders and the public.
Measure 1.3.3:	Use data to recommend and inform public health actions.

DOMAIN 2:

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

Measure 2.1.1:	**Maintain surveillance protocols.**
Measure 2.1.2:	Communicate with surveillance sites.
Measure 2.1.3:	**Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.**
Measure 2.1.4:	Maintain protocols for investigation of public health issues.
Measure 2.1.5:	Maintain protocols for containment and mitigation of public health problems and environmental public health hazards.
Measure 2.1.6:	Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.
Measure 2.1.7:	Use surveillance data to guide improvements.
Measure 2.1.8 (State health departments only):	Communicate about and support investigations at the Tribal or Local Level.
Measure 2.2.1:	**Maintain a public health emergency operations plan (EOP).**
Measure 2.2.2:	**Ensure continuity of operations during response.**
Measure 2.2.3:	Maintain and expedite access to personnel and infrastructure for surge capacity.
Measure 2.2.4:	Ensure training for personnel engaged in response.
Measure 2.2.5:	**Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency.**
Measure 2.2.6:	**Maintain and implement a process for urgent 24/7 communications with response partners.**
Measure 2.2.7:	**Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.**
Measure 2.2.8 (State health departments only):	Provide communications and other support to Tribal and local health departments related to response efforts.

DOMAIN 3:

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

Measure 3.1.1:	**Maintain procedures to provide ongoing, non-emergency communication outside the health department.**
Measure 3.1.2:	Establish and implement a department-wide brand strategy.
Measure 3.1.3:	Communicate what public health is, what the health department does, and why it matters.
Measure 3.1.4:	Use a variety of methods to make information available to the public and assess communication strategies.
Measure 3.2.1:	Design communication strategies to encourage actions to promote health.
Measure 3.2.2:	**Implement health communication strategies to encourage actions to promote health.**

DOMAIN 4:

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

Measure 4.1.1:	Engage in active and ongoing strategic partnerships.
Measure 4.1.2:	**Participate actively in community health coalition(s).**
Measure 4.1.3:	Engage with community members to address public health issues and promote health.

DOMAIN 5:

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

Measure 5.1.1:	Maintain awareness of public health issues that are being discussed by those who set policies and practices that impact on public health.
Measure 5.1.2:	**Examine and contribute to improving policies and laws.**
Measure 5.2.1:	Engage partners and members of the community in a community health improvement process.
Measure 5.2.2:	**Adopt a community health improvement plan.**
Measure 5.2.3:	Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.
Measure 5.2.4:	**Address factors that contribute to specific populations' higher health risks and poorer health outcomes.**

DOMAIN 6:

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

Measure 6.1.1:	Maintain knowledge of laws to promote and protect the public's health.
Measure 6.1.2:	Investigate complaints pertaining to public health regulations.
Measure 6.1.3:	Conduct and monitor inspection activities of regulated entities according to a schedule.
Measure 6.1.4:	**Conduct enforcement actions.**
Measure 6.1.5:	Coordinate notification of enforcement actions among appropriate agencies.
Measure 6.1.6:	Inform the public about enforcement activities.
Measure 6.1.7:	Identify and implement improvement opportunities to increase compliance.

DOMAIN 7:

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

Measure 7.1.1:	Engage with health care delivery system partners to assess access to health care services.
Measure 7.1.2:	Implement and evaluate strategies to improve access to health care services.
Measure 7.1.3 (State health departments only):	Establish or improve systems to facilitate availability of high-quality health care.
Measure 7.2.1:	**Collaborate with other sectors to improve access to social services.**
Measure 7.2.2:	Collaborate with other sectors to ensure access to care during service disruptions.

DOMAIN 8:

Build and support a diverse and skilled public health workforce.

Measure 8.1.1 (State health departments only):	Build relationships with educational programs that promote the development of future public health workers.
Measure 8.1.1 (Tribal and local health departments only):	Collaborate to promote the development of future public health workers.
Measure 8.1.2:	**Recruit a qualified and diverse health department workforce.**
Measure 8.2.1:	**Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.**
Measure 8.2.2:	**Provide professional and career development opportunities for all staff.**
Measure 8.2.3:	Build a supportive work environment.
Measure 8.2.4 (State health departments only):	Advance Tribal and local health department workforce development efforts.

DOMAIN 9:

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

Measure 9.1.1:	**Establish a performance management system.**
Measure 9.1.2:	Implement the performance management system.
Measure 9.1.3:	Implement a systematic process for assessing customer satisfaction with health department services.
Measure 9.1.4:	Establish a process that guides health department quality improvement efforts across the department.
Measure 9.1.5:	**Implement quality improvement projects.**
Measure 9.1.6:	Promote a culture of quality by engaging staff at all organizational levels in performance management and quality improvement.
Measure 9.1.7 (State health departments only):	Advance Tribal and local health department performance management systems or quality improvement.
Measure 9.2.1:	**Identify and use applicable research and practice-based information for program development and implementation.**
Measure 9.2.2:	Evaluate programs, processes, or interventions.
Measure 9.2.3:	Communicate research findings, including public health implications.
Measure 9.2.4:	Foster innovation.
Measure 9.2.5 (Tribal and State health departments only):	Foster research.
Measure 9.2.6 (State health departments only):	Provide support to Tribal and local health departments in applying relevant research results or evidence-/practice-based learnings.

DOMAIN 10:

Build and maintain a strong organizational infrastructure for public health.

Measure 10.1.1:	Conduct a department-wide strategic planning process.
Measure 10.1.2:	**Adopt a department-wide strategic plan.**
Measure 10.1.3:	Monitor implementation of the department-wide strategic plan.
Measure 10.2.1:	**Manage operational policies including those related to equity.**
Measure 10.2.2:	**Maintain a human resource function.**
Measure 10.2.3:	**Support programs and operations through an information management infrastructure.**
Measure 10.2.4:	**Protect information and data systems through security and confidentiality policies.**
Measure 10.2.5:	Ensure clean, safe, accessible, and secure facilities.
Measure 10.2.6:	**Oversee grants and contracts.**
Measure 10.2.7:	**Manage financial systems.**
Measure 10.2.8:	Evaluate finances and seek needed resources to support ongoing and emergent needs.
Measure 10.3.1:	Deliberate and resolve ethical issues.
Measure 10.3.2:	Orient the governing entity and advisory board.
Measure 10.3.3:	**Communicate with governance routinely and on an as-needed basis.**
Measure 10.3.4:	**Access and use legal services in planning, implementing, and enforcing public health initiatives.**

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.

MEASURES:		
Assessment & Surveillance	**1.1.1:**	Develop a community health assessment.
	1.2.1:	Collect primary non-surveillance data.
	1.2.2:	Participate in data sharing with other entities.
	1.3.1:	Analyze data and draw public health conclusions.

Community Health Assessment

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

Development of a community health assessment 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 community health assessment 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 assessment 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 health assessment process and are provided with key findings from the assessment in a manner they understand.

A collaborative approach to developing the community health assessment 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 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 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 1.1.1:

Develop a community health assessment.

Purpose & Significance

The purpose of this measure is to assess the Tribal, local, or state health department's comprehensive community health assessment of the population of the jurisdiction served by the health department. The community health assessment tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population. A health assessment identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the community health assessment may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods.

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

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

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

MEASURE 1.1.1: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following: i. Health status. ii. Health behaviors.	**For required element e:** The intent of required element e is to present a summary of themes and findings based on the data in required element c, above. To examine what disparities may exist in the health status in the community, the CHA could include differences in rates of, for example, illness, death, chronic conditions, self-reported health and well-being, and other types of health outcomes in relationship to demographic factors (e.g., race, ethnicity, gender, sexual orientation, disability status or special health care needs, or geographic location). Similarly, the CHA will examine differences in health behaviors, for example, smoking or vaping rates, eating or exercise habits, or high-risk sexual behavior. Examples of ways the data could be presented include, for example, a table, or cross-tabulation that demonstrates differences in chronic disease morbidity by race and ethnicity; differences in smoking rates by age; or a map showing poorer health outcomes by zip code. It could also include a description of how themes from focus groups or townhalls varied based on neighborhood or demographics of participants.		
f. A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment.	**For required element f:** Health equity relates to social justice in health; that is, everyone has a fair and just opportunity to be as healthy as possible. The description of factors that contribute to inequities may relate to conditions that vary by population, for example, the availability of affordable housing for low- and middle-income families; availability of culturally and linguistically appropriate services for limited English-speaking populations; or how conditions vary by neighborhood such as school funding or access to health services. Inequities related to the built environment might include vulnerability to climate change, or the availability of grocery stores, parks, sidewalks, or transportation. As part of identifying factors that contribute to health challenges within the community, the description may also address related policies (e.g., taxation, education, transportation, or insurance status), social or structural determinants of health, or other the unique characteristics of the community that impact health status. Social determinants of health include factors in which people are born, live, and grow that influence health beyond a person's control. Social determinants may include structural determinants or "root causes" of health inequities. Structural determinants include factors such as the political, economic, or social policies that affect income, education, or housing conditions. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual orientation, or other socially defined group of people. The description could include equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes.		
g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges. The CHA must address the jurisdiction as described above.	**For required element g:** The intent of this required element is to ensure that when assessing the health of the community, the partnership is also learning about the assets and resources that can enhance community well-being. The CHA does not need to include an exhaustive list of all assets. A section may be dedicated to assets or resources, as a list or narrative, or they may be woven throughout the document. Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, or mutual aid groups or support circles. 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).		

MEASURE 1.2.1:

Collect non-surveillance population health data.

Purpose & Significance

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

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

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

MEASURE 1.2.2:

Participate in data sharing with other entities.

Purpose & Significance

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

MEASURE 1.2.2:	Guidance	Number of Examples	Dated Within
Required Documentation 1		2 examples	2 years
1. Participation in data sharing with other entities, by either: a. Providing data to another entity; **or** b. Receiving data from another entity; **or** c. Providing a data use agreement with another entity. The data being shared must include record-level data.	The intent of the requirement is to demonstrate sharing or receiving data that can be used to gain new insights by enabling the recipient of those data to conduct analyses looking for relationships among the data points or potentially to merge the data with other data sets. Sharing data summaries or aggregate data would **not** meet the intent of this requirement. Instead, the data will include record-level data. That is, there would be data for each unit (e.g., each individual, jurisdiction, facility, body of water or other specimen collection site, or clinic) in the dataset. For example, the health department could receive a dataset with a row of information about each patient from a local hospital, which the health department could use to analyze relationships (e.g., relationships between disease prevalence and the patients' zip code or demographics). The data could also be used to assist in outbreak containment by sharing surveillance data with another health department, for example. Data that the health department receives from other entities could include, for example, school performance or absences, capacity of licensed childcare facilities, land use zoning, receipt of public benefits, eviction notices, building inspections or complaints, calls to the fire department or emergency services, or utilization of public transportation options. Sharing deidentified data (i.e., data where the names or other information that would identify individuals has been removed) would be acceptable. The entity could be, for example, an organization, an individual, another local or Tribal health department, or the state health department. Data could be submitted or received through a data system. Data systems could include, for example, registries (e.g., cancer registries or immunization registries); vital records data; or data in web-based infectious disease reporting systems. Electronic heath record (EHR) data could also be considered if, for example, the data from an EHR operated by the health department are made available to other providers through a health information exchange or if the health department is able to access EHR data from other providers through a health information organization. Submitted or received data could also be shared outside of a data system, such as providing environmental public health data (e.g., a data set including information about water quality readings over time or across sites) through email. The documentation could be provided via an intermediary. For example, a Tribal health department could provide documentation demonstrating that they work with a Tribal Epidemiology Center to establish data sharing. In respecting the sovereignty of the Tribe to make the most appropriate decision about sharing data, Tribal health departments can determine whether and under which circumstances to share their data. **Documentation Examples** Documentation could be, for example, emails, screen shots documenting data were shared or received through web pages or a portal, or data use agreements.		

MEASURE 1.3.1:

Analyze data and draw public health conclusions.

Purpose & Significance

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

MEASURE 1.3.1: Required Documentation 1	Guidance	Number of Examples 1 example	Dated Within Analysis conducted within 5 years (data may be older)
1. Conclusions from **quantitative** analysis of data relevant to public health, which include:	The intent of this requirement is to show what has been learned from the analysis of quantitative data. Data used in the analysis can include all primary data, all secondary data, or a combination of primary and secondary data. The actual data set(s) used in the analysis do **not** need to be provided. The health department could use reports produced by others, such as the state health department, an academic institution, or other organizations. However, data analysis developed by others must have a connection to the jurisdiction and the populations served by the health department and contain information relevant to public health. Providing a spreadsheet of raw, unanalyzed data would **not** meet the intent of this requirement. Program evaluation, customer satisfaction, or employee satisfaction do **not** meet the intent of this requirement. Data relevant to public health may include social conditions that have an impact on the health of specific populations served, for example, unemployment, poor housing, lack of transportation, high crime residential areas, poor education, poverty, or lack of accessible facilities for physical activity. Data sources could include, for example, Behavioral Risk Factor Surveillance Survey (BRFSS) data, youth survey data (e.g., YRBSS), PLACES data portal, HUD Location Affordability Index, AHRQ Social Determinants of Health Database, USDOT Local Area Transportation Characteristics for Households (LATCH), USDA Food Environment Atlas, EPA Environmental Dataset Gateway, vital statistics, workplace fatality or disease investigation results, outbreak investigation results, environmental or occupational public health hazard data, key health indicator data, health disparities data, environmental data, socioeconomic data, stratified racial and ethnic health disparities data, hospital data, or not-for-profit organizations' data (for example, poison control center data). It can also include surveys that collect quantitative data (e.g., responses to multiple choice questions, true or false questions, questions with a Likert scale or other form of rating, or questions that ask for a numerical answer).		
a. Comparisons.	**For required element a:** Documentation will include findings related to the comparisons, which could be presented, for example, in a graphic form (e.g., a bar graph that compares differences in the prevalence of various health conditions by socioeconomic status) or in a narrative (e.g., a paragraph that describes numeric or percentage differences survey responses based on the age of the respondents). Comparisons could include, for example (1) other similar socio-geographic areas, sub-state areas, the state, or nation, (2) different population groups, such as age, gender, race, SES, or (3) similar data for the same population gathered at an earlier time to establish trends over time (e.g., rates of sexually transmitted diseases over the past five years, childhood immunization rates over the past eight quarters, unemployment rates over the past five years, or crime rate over the past two years).		
b. The analytic process used. (If the analytic process used is not evident in the example, it could be indicated in the Documentation Form.)	**For required element b:** Analytic processes for quantitative data could be, for example, crosstabs (i.e., tables showing how the mean, median, or count varies by demographic category), tests of significance (T-test, chi-square, ANOVA), cluster analysis, factor analysis, or regression analysis. The intent of this element is to show that analysis has been conducted to understand the relationships between variables. This type of analysis can be conducted using spreadsheets and does **not** require the use of statistical applications. The analytic process may be indicated in the Documentation Form.		

MEASURE 1.3.1: Required Documentation 1	Guidance	Number of Examples	Dated Within
		1 example	Analysis conducted within 5 years (data may be older)
c. Conclusions. At least some data used in the analysis must be specific to the population served by the health department or a subset of the jurisdiction's population.	**For required element c:** Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications for the community, drawing inferences about the relationship between different variables, or making hypotheses about potential causes of the findings. This could be presented as part of, for example, an executive summary, a list of recommendations, or a discussion or implications section of a report. **Documentation Examples** Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment.		

MEASURE 1.3.1: Required Documentation 2	Guidance	Number of Examples	Dated Within
		1 example	Analysis conducted within 5 years (data may be older)
2. Conclusions from **qualitative** analysis of data relevant to public health, which include:	The intent of this requirement is to show what has been learned from qualitative data. Data used in the analysis can include all primary data, all secondary data, or a combination of primary and secondary data. Data sources could include, for example, focus groups, town halls, interviews, or open-ended questions in surveys. Providing a transcript of raw, unanalyzed information collected from a focus group or spreadsheet of all the free-text responses of a survey would **not** meet the intent of this requirement. The actual data set(s) used in the analysis do **not** need to be provided. The health department could use reports produced by others, such as the state health department, an academic institution, or other organizations. However, data analysis developed by others must have a connection to the jurisdiction and the populations served by the health department and contain information relevant to public health. Program evaluation, customer satisfaction, or employee satisfaction do **not** meet the intent of this requirement. Data relevant to public health may include social conditions that have an impact on the health of specific populations served, for example, unemployment, poor housing, lack of transportation, high crime residential areas, poor education, poverty, or lack of accessible facilities for physical activity.		
a. The analytic process used. (If the analytic process used is not evident in the example, it could be indicated in the Documentation Form.)	**For required element a:** Analytic processes for qualitative data could be, for example, content analysis or thematic analysis. The intent of the analysis is to gain a deeper understanding of the raw data. This type of analysis can be conducted using spreadsheets and does not require the use of statistical applications. The analytic process may be indicated in the Documentation Form.		

MEASURE 1.3.1: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example	**Dated Within** Analysis conducted within 5 years (data may be older)
b. Conclusions. At least some data used in the analysis must be specific to the population served by the health department or a subset of the jurisdiction's population.	**For required element b:** Drawing conclusions involves reviewing the data and making meaning from those data. It could entail, for example, identifying implications for the community, drawing inferences about the relationship between different themes identified in the data, or making hypotheses about potential causes of the findings. This could be presented as part of, for example, an executive summary, a list of recommendations, a discussion or implications section of a report. **Documentation Examples** Documentation could be, for example, a memo, report section, presentation, or excerpts from the state/Tribal/community health assessment.		

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.

MEASURES:		
Assessment & Surveillance	**2.1.1:**	Maintain surveillance systems.
	2.1.3:	Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.
Communications	**2.2.5:**	Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency.
Emergency Preparedness & Response	**2.2.1:**	Maintain a public health emergency operations plan (EOP).
	2.2.2:	Ensure continuity of operations during response.
	2.2.6:	Maintain and implement a process for urgent 24/7 communications with response partners.
	2.2.7:	Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.

MEASURE 2.1.1:

Maintain surveillance protocols.

Purpose & Significance

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

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

MEASURE 2.1.1: Required Documentation 2	Guidance	Number of Examples 2 processes or protocols, or a process or protocol that addresses 2 or more surveillance systems	Dated Within 5 years
2. Process or protocol for public health surveillance data. For each surveillance system, the process or protocol must include:	The intent of this requirement is to assess what process(es) or protocol(s) are in place for surveillance systems to collect data in a systematic, continuous manner. While surveys such as BRFSS and NHIS provide critical information about the health of the population, that form of data collection is covered in Domain 1 and would **not** meet the intent of this requirement. If vital records data are collected by the health department as part of the surveillance system, vital records should be included in the documentation for this requirement. The requirement is to provide one process or protocol that addresses multiple surveillance systems the health department is involved in or two processes **or** protocols that each address one surveillance system. Infectious illness (or communicable disease) could include, for example, HIV, sexually transmitted infections, vector-borne diseases, vaccine-preventable diseases, enteric diseases, healthcare associated infections, Hepatitis C, or influenza and viral respiratory diseases.		

MEASURE 2.1.1: Required Documentation 2	Guidance	Number of Examples 2 processes or protocols, or a process or protocol that addresses 2 or more surveillance systems	Dated Within 5 years
	If the health department plays any role in a particular required element, the process or protocol will address how the health department performs its role in that element. For example, if a health department reports data into a surveillance system maintained or operated by another entity, required element a will describe how the health department reports those data. If the health department has no role in a particular required element, the process or protocol will address how another agency conducts that element.		
a. How data are reported or collected 24/7.	**For required element a:** Data could be collected from, for example, health care providers, hospitals, laboratories, or other individuals or entities in a variety of ways. Methods for 24/7 data collection could be, for example, a designated telephone line, email addresses, or ability to submit a report electronically. Reports may be received by a contractor or by a call center (e.g., a poison control center), via regional or state agreements, or other arrangement. The health department defines from whom reports are received.		
b. What data quality control measures are in place.	**For required element b:** Surveillance data quality control measures could include, for example, checking for duplication; addressing outliers in the data; or other steps used to clean the data.		
c. How data are analyzed to identify deviations from expected trends.	**For required element c:** While the process or protocol may not specify one method of data analysis used for all data analysis, it will discuss how the health department is able to identify when the surveillance data deviate from expected trends or how fluctuations are identified. Knowing when acceptable thresholds have been exceeded will allow the health department to initiate additional investigation or mitigation steps.		
d. How data are disaggregated by subpopulation.	**For required element d:** The process or protocol will discuss how the health department is able to view data specific to subpopulations. Data could be disaggregated by, for example, race, ethnicity, gender, age, other demographics, or geographic location. This can be used to identify the disproportionate impact of health conditions or environmental health hazards among subpopulations.		
e. Which surveillance data are considered to be confidential.	**For required element e:** The process or protocol for determining which surveillance data are confidential could be, for example, a set of criteria used for making this determination or a list of fields from the surveillance system.		

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

MEASURE 2.1.3:

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

Purpose & Significance

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

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

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

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

MEASURE 2.2.1:

Maintain a public health emergency operations plan (EOP).

Purpose & Significance

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

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

MEASURE 2.2.1: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 3 years
	The documentation could be, for example, within the EOP, a separate annex, or another attachment such as a jurisdictional risk assessment (JRA).		
d. At least two processes in place to meet the needs of individuals at higher risk (identified in required element c).	**For required element d:** Processes to meet the needs (e.g., transportation needs, translation services, special outreach to counteract historical mistrust) of individuals at higher risk may be incorporated within the emergency operations plan or separate plan, such as, a Communication, Maintaining Health, Independence, Support/Services, and Transportation (CMIST) profile or Access and Functional Needs (AFN) plan.		
e. The lead role agency(ies), as well as the responsibilities of the health department (if any) specific to the following areas: i. Medical countermeasures ii. Mass care iii. Mass fatality management iv. Mental/behavioral health v. Non-pharmaceutical interventions, including legal authority to isolate, quarantine, and, as appropriate institute social distancing vi. Responder safety and health vii. Volunteer management (Lead role agency(ies) and page numbers, as appropriate, will be indicated on the Documentation Form.	**For required element e:** The Documentation Form contains a table in which the health department will indicate for each of the seven areas listed which agency(ies) is designated as the lead agency, whether it is the health department or an emergency response partner (e.g., hospitals and health care providers, emergency management agency, American Red Cross, mortuary, or coroners). The health department will also use the Documentation Form table to indicate page numbers where the health department's responsibilities (if any) for each of those seven areas are described within the emergency operations plan, annex(es), or attachment(s). If the emergency management agency (EMA)—sometimes referred to as the office of emergency management (OEM) or emergency management office (EMO)—is the lead agency for either carrying out the function or designating a lead agency based on the specific emergency, that can be indicated in the Documentation Form for each area where it applies.		
f. The process of declaring a public health emergency.	**For required element f:** The process to declare a public health emergency could include, for example, what authorities are needed or the steps needed to officially make an emergency declaration. This could include the steps (formal or informal) the health department would take, as well as formal steps other entities take to declare a public health emergency. Process steps that are not formally documented may be described in the Documentation Form.		

MEASURE 2.2.1: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 3 years
g. Activation of public health emergency operations, including levels of activation based on triggers or circumstances.	**For required element g:** Levels of activation are based on triggers or circumstances. These may be identified in communication with the incident commander or unified command based on the jurisdiction's risk analysis.		
h. The process for collaborative review and revision of the plan. The public health EOP must cover the entire jurisdiction served by the health department or multiple EOPs must be provided to cover the entire jurisdiction.	**For required element h:** The process will show how the plan is reviewed and how revisions are considered, in collaboration with stakeholders. The review process could describe how the jurisdiction determines if there are appropriate revisions based on, for example, learnings from drills, exercises, or actual events in the jurisdiction; updates to guidance from the CDC (e.g., PHEP requirements) or other national, state, or regional entities; current risk assessments; or changes in the population or the risk factors in the jurisdiction (e.g., adding provisions to address fires if that risk increases or including outreach in additional languages or using community health workers, community health representatives, or others to better reach subpopulations).		

MEASURE 2.2.2:

Ensure continuity of operations during response.

Purpose & Significance

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

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

MEASURE 2.2.5:

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

Purpose & Significance

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

MEASURE 2.2.5: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
1. A risk communication plan that:	The risk communication plan outlines the methods to provide accurate, timely, effective communications during an emergency. There is no required format for the plan. It could be part of an overall department emergency operations plan. The health department may provide a communication plan that includes both non-emergency and emergency communications, as long as the plan delineates which processes are used for routine communications, emergency situations, or both. A risk communication plan may also be termed, for example, as an emergency communication plan or crisis communication plan or policy. Health departments may provide a written MOU or MOA with an external agency to perform risk communications on behalf of, or in collaboration with the health department. For example, a Tribal health department can provide an agreement with an external agency, such as a local health department, with clearly delineated roles for Tribal and non-Tribal staff and elected officials involved in the plan. For Tribal health departments, documentation could reference an existing, approved Tribal policy that identifies another Tribal employee or program (e.g., the Tribal emergency management planner) as being responsible for the risk communication plan and its implementation. In these instances, the health department may provide the risk communication plan or procedures of the external agency showing how required elements a-i are performed.		
a. Describes the process used to develop accurate and timely messages.	**For required element a:** To ensure messages are accurate, the plan could include, for example, provisions for a review of communications by experts or a process for fact checking. Part of ensuring accuracy is making sure that the health department is not omitting data that provide important context and is being transparent about how data may be updated or change over time. To ensure messages are timely, the plan could, for example, include guidance about target timeframes for responding to information requests or flow charts for content review with target timeframes. Because conditions and scientific understanding can change rapidly during an emergency, the plan may include provisions about how the health department regularly revisits previously released statements and informational materials to update them as new information emerges. The plan might also describe resources the health department uses in developing messages, such as the CDC's Crisis and Emergency Risk Communication tools.		
b. Describes methods to communicate necessary information to the entire community, including subpopulations who are at higher risk.	**For required element b:** Methods of communications will vary based on the community and could include, for example, the use of visuals or materials written in plain language. The entire community includes subpopulations and individuals who are at higher risk, which may be identified, for example, in a Communication, Maintaining Health, Independence, Services and Support, Transportation (CMIST) profile or Access and Functional Needs (AFN) plan. Subpopulations or at-risk individuals could include, for example, children, older adults, or pregnant women, as well as individuals who may need additional response assistance, such as individuals with disabilities, who live in institutional settings, from diverse cultures, who have limited English proficiency or are non-English speaking, with low literacy, who are transportation disadvantaged, who have chronic medical disorders, who have pharmacological or substance dependency, or are transient (e.g., individuals who are unhoused or migrant farm workers). Individuals who do not trust the government or medical research due to a history of mistreatment might also be considered.		

MEASURE 2.2.5: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 plan	**Dated Within** 5 years
c. Addresses misconceptions or misinformation.	**For required element c:** Addressing misconceptions or misinformation can help prevent public alarm. Methods could include, for example, proactively engaging with the public to correct misinformation, using technology or social media platforms to share accurate information from reputable sources, using social math (designed to make statistics and other data more understandable to the audience) or infographics to convey scientific messages or terminology, or developing localized messaging in collaboration with community groups, members, or local organizations. Using multiple, credible sources is one way to help preserve the public's trust in public health messages.		
d. Describes the process to expedite approval of messages to the public during an emergency.	**For required element d:** Expediting approval of messages could include, for example, establishing a process to clear information simultaneously (e.g., gathering subject matter experts, public information officers, and other decision-makers together at once to expedite the approval process), developing mechanisms to conduct a courtesy check with other response partners for message consistency, prioritizing messages on a "need to know" versus "want to know" basis, developing a strategy for message clearance that identifies key subject matter experts who are available to review messages for accuracy or policy advisors to ensure information is consistent with policies or laws, or developing a strategy to rapidly disseminate communication through web, social media, or media outlets. The approval process may also be part of the incident command system deployed in the community.		
e. Describes how information will be disseminated in the case of communication technology disruption.	**For required element e:** Methods in case of technology disruption could include, for example, radios or radio public service announcements, internet connections that use cellular data instead of wi-fi (e.g., air cards, tablets, cell phones), megaphones, door-to-door communication, or printed materials.		
f. Describes the process for managing and responding to inquiries from the public during an emergency.	**For required element f:** Methods for managing and responding to inquiries from the public could include, for example, operating call centers, managing and responding to inquiries on social media or websites, or monitoring and responding to questions or topics raised by the public through the media, in person, or other channels.		
g. Describes the process to coordinate the communications and development of messages among partners during an emergency.	**For required element g:** Methods could include, for example, steps taken to ensure messaging with partners is complementary and not contradictory, or a process to coordinate collective communications in order to reach intended target audiences.		

MEASURE 2.2.5: Required Documentation 1	Guidance	Number of Examples	Dated Within
		1 plan	5 years
h. Contains a list with media contact information.	**For required element h:** The list could include contact information related to, for example, television, radio, newspaper, or other forms of conveying information to the public in the community (e.g., websites that are commonly considered as a source of local news). Restricted information may be redacted from the contact list.		
i. Describes the procedure for keeping the media contact list current and accurate.	**For required element i:** The procedure could outline, for example, the frequency, staff member responsible, and elements of the media contact list that are reviewed and updated.		

MEASURE 2.2.5: Required Documentation 2	Guidance	Number of Examples	Dated Within
		2 examples; 1 with news media and 1 with social media	5 years
2. Communication with the public during an emergency. One example must demonstrate how the department worked with the news media to disseminate information during a public health emergency. The other example must demonstrate use of social media. One of the two examples must show how the department utilized a strategy specifically focused on communicating with a population that requires special communication considerations. If no emergencies have occurred within the last 5 years, the health department must indicate that to PHAB and no documentation is needed for Required Documentation 2.	The intent of this requirement is to demonstrate multiple methods of communicating with the public during an emergency. The health department could demonstrate working with the news media through, for example, press conferences or interviews (radio or television), media packets, publication of a press release, or public service announcement. Use of social media could include, for example, posts to Facebook, Twitter, or other platforms. Special considerations could address, for example, linguistic appropriateness, including both the language(s) used to communicate a message as well as tailoring messaging to address considerations such as health literacy. Other methods could consider people with disabilities (e.g., using sign language interpreters) or people with behavioral health or substance use disorders. Other considerations might address cultural humility, which considers the way people view, experience, and make choices about their health based on multiple factors (e.g., religion, economic and educational factors, cultural values, beliefs, customs, and ways of living). Health departments could demonstrate working closely with individuals and organizations who are considered trusted messengers for their communities (e.g., community and religious leaders, school leaders, local elected officials, or heads of cultural organizations) to support bi-directional information sharing. The documentation could be supplemented with an explanation in the Documentation Form to indicate how the example shows the department focused on communicating with a population that requires special communication considerations. The examples could be from an emergency that activated the public health EOP, but they do **not** need to be. They could also be from, for example, a flu outbreak in a nursing home that did not cause the EOP to be activated. **Documentation Examples** Documentation could be press releases, television or radio interviews, or tweets.		

MEASURE 2.2.6:

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

Purpose & Significance

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

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

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

MEASURE 2.2.7:

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

Purpose & Significance

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

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

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

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

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

DOMAIN 3

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

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

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

MEASURES:		
Communications	**3.1.1:**	Maintain procedures to provide ongoing, non-emergency communication outside the health department.
	3.2.2:	Implement health communication strategies to encourage actions to promote health.

MEASURE 3.1.1:

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

Purpose & Significance

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

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

MEASURE 3.1.1: Required Documentation 1	Guidance	Number of Examples 1 department-wide procedure or set of procedures	Dated Within 5 years
c. Include the process for coordinating with community partners to promote the dissemination of unified public health messages.	**For required element c:** Partners might include community or volunteer organizations, governing entity, businesses and industries, academic institutions, or others including those who represent priority populations. The procedure could involve, for example, convening meetings with community partners to discuss methods of disseminating unified and accurate information appropriate for the audience. For example, the procedure could include working with partners to develop coordinated press releases, public service announcements (PSAs), or joint web or social media campaigns. An asset-based approach focuses on the context of which community partners are involved and what resources are available in the community to appropriately tailor communication for different audiences.		
d. Describe the process to maintain a contact list of key stakeholders for communications.	**For required element d:** The procedure could involve, for example, the regular review and process steps to update contact information and ensure the list is current. Key stakeholders for communications could include, for example, the public information officers at other health departments (e.g., state, local, Tribal, or military health departments) or other branches of government (e.g., county council, department of education, office of the governor) or communications staff at nonprofit organizations that can help expand the health department's communication reach (e.g., organizations whose constituents represent individuals with particular health concerns or subpopulations in the community). The media is a key stakeholder for communications; however, because the process for maintaining a media list is included in Measure 2.2.5 A, it is **not** required for this requirement.		
e. Identify which department staff position(s) is designated to perform the functions of a public information officer for regular communications. The procedure must define this position's responsibilities, which must include: i. Maintaining media relationships. ii. Creating appropriate, effective public health messages. iii. Managing other communications activities.	**For required element e:** Documentation could be, for example, a job description or other description of responsibilities related to ongoing, non-emergency communications. The public information officer (PIO) function may be a dedicated position or performed by other staff; (e.g., health director, deputy health director, or other assigned staff). The description will reflect the duties of the public information function regardless of the individual's job title. The PIO may be the same position during regular and emergency communications or may be different staff depending on the situation.		

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

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

MEASURE 3.2.2:

Implement health communication strategies to encourage actions to promote health.

Purpose & Significance

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

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

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

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

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.

MEASURES:		
Community Partnership Development	**4.1.2:**	Participate actively in community health coalition(s).

MEASURE 4.1.2:

Participate actively in community health coalition(s).

Purpose & Significance

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

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

MEASURE 4.1.2: Required Documentation 1	Guidance	Number of Examples	Dated Within
		2 examples of topic or population specific coalitions or one example of a coalition that works on 2 or more issues	2 years

d. Modes and frequency of interaction. (If the modes and frequency of interaction is not evident in the example, it could be indicated in the Documentation Form.) The health department must actively participate in the coalition, although the coalition may be convened or facilitated by a representative of another community organization or agency.	**For required element d:** The modes (methods of communication) and frequency of interaction will be described. For example, monthly or quarterly meetings could take place virtually or in-person or other regular communications, such as each member reporting quarterly into a shared file system could be described. Each coalition will determine the modes and frequency of interaction necessary for the group. The modes and frequency of interaction may be indicated in the Documentation Form. **Documentation Examples** Documentation could be a summary or report of the coalition(s), indicating ongoing activities; meeting minutes and agendas; progress reports; or evaluations. A roster of members will **not** be sufficient for this requirement, but it could be used to demonstrate required elements b and c.

MEASURE 4.1.2: Required Documentation 2	Guidance	Number of Examples	Dated Within
		2 examples	5 years

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

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.

MEASURES:		
Policy Development & Support	**5.1.2:**	Examine and contribute to improving policies and laws.
Community Partnership Development	**5.2.2:**	Adopt a community health improvement plan.
Equity	**5.2.4:**	Address factors that contribute to specific populations' higher health risks and poorer health outcomes.

MEASURE 5.1.2:

Examine and contribute to improving policies and laws.

Purpose & Significance

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

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

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

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

Community Health Improvement Plan

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 Tribal or local level. 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 5.2.2:

Adopt a community health improvement plan.

Purpose & Significance

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

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

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

MEASURE 5.2.4:

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

Purpose & Significance

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

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

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

DOMAIN 6

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

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

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

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

MEASURES:		
Policy Development & Support	**6.1.4:**	Conduct enforcement actions.

MEASURE 6.1.4:

Conduct enforcement actions.

Purpose & Significance

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

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

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

MEASURE 6.1.4:

Required Documentation 3

3. Information provided to regulated entities about their responsibilities related to public health laws.

Documentation must include both the information provided **and** description of its distribution. (If the description of distribution is not evident in the example, it could be indicated in the Documentation Form.)

One of the examples must demonstrate consideration of cultural humility, literacy, or other special communication considerations.

If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.

Guidance

Number of Examples	Dated Within
2 examples	5 years

The information to regulated entities could be, for example, providing information or education to food service or pool operators on how to comply with safety requirements or regulations.

Cultural humility, literacy, or other special considerations could include, for example, providing information in other languages, using plain language or pictures, using interpreters or staff familiar with cultural backgrounds of regulated entities. This could include, for example, use of interpreters to communicate regulations or cultural considerations taken into account while providing education to food establishments, or engaging staff familiar with Islamic law and customs in Halal food preparation or Jewish laws and traditions related to Kosher food preparation. The documentation could be supplemented with a description in the Documentation Form of how the consideration of cultural humility, literacy, or other special communication considerations were accomplished.

Documentation Examples

Documentation could be, for example, a set of FAQs sent to regulated entities, newsletters, training sessions, public meetings, documentation of technical assistance and information (provided through email or phone logs), pamphlets, posters, press releases, or social media. If it is not evident within the documentation, the description of distribution may be included on the Documentation Form.

MEASURE 6.1.4:

Required Documentation 4

4. Hearings, meetings, or other official communications with regulated entities regarding a compliance plan.

Examples must include any resulting compliance plans.

If the health department has no enforcement authority, this will be indicated to PHAB and **no** documentation is needed for this requirement.

Guidance

Number of Examples	Dated Within
2 examples	5 years

The regulated entity, based on the law, could be an organization, business, or individual. The compliance plan has no specific format and will be determined by law or health department protocol. The compliance plan may have initiated from a routine inspection or a complaint.

Documentation Examples

Documentation could be, for example, minutes of an official meeting with the regulated entity that describe the compliance plan, or an enforcement letter with accompanying compliance plan sent to the regulated entity.

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.

MEASURES:		
Community Partnership Development	**7.2.1:**	Collaborate with other sectors to improve access to social services.

MEASURE 7.2.1:

Collaborate with other sectors to improve access to social services.

Purpose & Significance

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

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

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

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.

MEASURES:		
Organizational Competencies	**8.1.2:**	Recruit a qualified and diverse health department workforce.
	8.2.1:	Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.
	8.2.2:	Provide professional and career development opportunities for all staff.

MEASURE 8.1.2:

Recruit a qualified and diverse health department workforce.

Purpose & Significance

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

MEASURE 8.1.2:

Required Documentation 1

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

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

Guidance

Number of Examples	**Dated Within**
2 examples	5 years

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

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

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

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

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

Tribal health departments may use Indian Preference hiring policies.

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

Documentation Examples

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

MEASURE 8.2.1:

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

Purpose & Significance

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

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

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

MEASURE 8.2.1: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
2. A list of learning or educational opportunities that relate to the gaps in capacity or capabilities identified within the workforce development plan (Required Documentation 1, required elements a or b) or the equity assessment (Required Documentation 1, required element c). At least one of the learning or educational opportunities will include training on equity, diversity, inclusion, or cultural humility.	The list of learning or educational opportunities could be part of the workforce development plan or a companion document. While the plans to address gaps in capacity or capabilities within the workforce development plan may include an objective(s) that training is needed (Required Documentation 1, required element e), the learning or educational opportunities list (Required Documentation 2) will specify the specific courses or training opportunities. The intent of this requirement is that the health department develop—or leverage existing—learning curricula that correspond to identified gaps in capacity or capability based on the assessment within the workforce development plan. Learning opportunities could help the health department to address capacity gaps by allowing existing staff to be cross trained to take on new roles. The list could consist of opportunities compiled and available through learning management systems, such as the Public Health Foundation's TRAIN Learning Network. The list could include, for example, learning and educational opportunities with a brief description of the content, learning objectives, availability or frequency of offerings, or format (e.g., in person or virtual). Topics for the staff training on equity, diversity, inclusion, or cultural humility could include, for example, examining biases and prejudices; developing cross-cultural skills; learning about specific populations' values, norms, traditions, and narrative; or learning, with people with lived experience, about how to develop programs and materials for individuals who have low literacy skills, speak a different language, or are blind or deaf. Trainings could include, for example, the Racial Equity Institute, Prevention Institute's Health Equity Training Series, the National Association of County and City Health Officials' Roots of Health Inequity, Robert Wood Johnson Foundation's Health Equity: Why it Matters, and How to Take Action, or trainings available through the Public Health Learning Network (PHLN), or Public Health Foundation's TRAIN Learning Network.		

MEASURE 8.2.2:

Provide professional and career development opportunities for all staff.

Purpose & Significance

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

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

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

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.

MEASURES:		
Accountability & Performance Management	**9.1.1:**	Establish a performance management system.
	9.1.5:	Implement quality improvement projects.
	9.2.1:	Identify and use applicable research and practice-based information for program development and implementation.

MEASURE 9.1.1:

Establish a performance management system.

Purpose & Significance

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

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

MEASURE 9.1.1: Required Documentation 1	Guidance	Number of Examples 1 performance management system	Dated Within 5 years
	Documentation may demonstrate a sub-set of the goals and objectives in the performance management system through screenshot(s) or other documentation. The documentation does **not** need to show every goal and objective, but will reflect the breadth of the goals and objectives included in the performance management system.		
b. A description of how the performance management system operates, including the process for how staff will: i. Enter data in the performance management system. ii. Monitor data on performance. iii. Communicate results on a regular reporting cycle. iv. Use data to guide decision-making. v. Use data to facilitate continuous quality improvement.	**For required element b:** The description of the performance management system could be a description, policy, or plan (separate plan or integrated with the QI plan or other health department plan). It will describe how the following processes generally occur, but does **not** need to go into detail about each individual objective. For example, in describing how staff enter data into the system, it would be sufficient to list the methods used to collate data into the system without indicating which method applies to each specific objective. The description will include the process for how staff do each of the following: i. Enter data in the system. Performance measurement data can be derived from multiple data systems or data collection processes. Some could be directly transferred into the performance management system from another data source (e.g., if there is a connection to HR, financing, or surveillance data systems) or could be entered by staff. ii. Monitor data on performance. This could include, for example, how data are tracked to determine whether progress has been made towards meeting the objectives. iii. Communicate results on a regular reporting cycle. This could include, for example, regularly summarizing data on performance objectives (e.g., monthly, quarterly, or annually) and sharing this information with stakeholders (e.g., the health department director, members of the governing entity, staff, or members of the public). Documentation of progress reporting could include, for example, a dashboard accessible to others, quarterly reports sent to stakeholders, newsletters, meeting agendas and minutes, or presentations. iv. Use data to guide decision making. The health department could use performance management data analyses to, for example, guide decisions on where resources should be allocated or adjusted to improve efficiencies or effectiveness, or identify an unmet community need. v. Use data to facilitate continuous quality improvement. Monitoring progress in performance management data could lead to the identification of a quality improvement project, for example.		
c. Linkages between the performance management system and strategic plan. (If the linkages are not evident in the example, they could be indicated in the Documentation Form.)	**For required element c:** Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities. The performance management system does **not** need to link to all elements of the strategic plan, but it will show where linkages are appropriate for effective planning and implementation. A statement simply stating the performance management system is aligned to the strategic plan would not suffice. The Documentation Form may be used to clarify or describe linkages, for example, by indicating which specific priorities in the strategic plan are being tracked through the performance management system.		

MEASURE 9.1.5:

Implement quality improvement projects.

Purpose & Significance

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

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

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

MEASURE 9.2.1 :

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

Purpose & Significance

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

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

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

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 for the jurisdiction served. Governing entities both directly and indirectly influence the direction of a health department and should play a key role in accreditation efforts. Variation exists regarding the structure, definition, roles, and responsibilities.

MEASURES:		
Organizational Competencies	**10.1.2:**	Adopt a department-wide strategic plan.
	10.2.2:	Maintain a human resource function.
	10.2.3:	Support programs and operations through an information management infrastructure.
	10.2.4:	Protect information and data systems through security and confidentiality policies.
	10.2.6:	Oversee grants and contracts.
	10.2.7:	Manage financial systems.
	10.3.3:	Communicate with governance routinely and on an as-needed basis.
	10.3.4:	Access and use legal services in planning, implementing, and enforcing public health initiatives.
Equity	**10.2.1:**	Manage operational policies including those related to equity.

MEASURE 10.1.2:

Adopt a department-wide strategic plan.

Purpose & Significance

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

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

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

MEASURE 10.2.1:

Manage operational policies including those related to equity.

Purpose & Significance

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

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

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

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

MEASURE 10.2.2:

Maintain a human resource function.

Purpose & Significance

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

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

MEASURE 10.2.3:

Support programs and operations through an information management infrastructure.

Purpose & Significance

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

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

MEASURE 10.2.4:

Protect information and data systems through security and confidentiality policies.

Purpose & Significance

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

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

MEASURE 10.2.4: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 policy or set of policies	**Dated Within** 5 years
	▪ Sensitive data are data that are not meant to be made public. Sensitive data systems could include, for example, immunization data registries, reportable disease records, or vital records. ▪ Mission-critical data are any data or systems that, if compromised or unavailable to users for long periods of time, would prevent the health department from being able to conduct its business functions. Mission-critical data or systems could include, for example, systems for collecting payment for environmental health licenses or permits. Policies for maintaining mission-critical data may include, for example, more frequent redundant data backups.		
ii. A process for user access management for electronic data and data systems.	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.		
iii. A process for maintaining confidentiality of data that are stored as paper versions, as appropriate.	iii. Confidentiality of paper versions of data could include, for example, use of locked file cabinets or storage areas/facilities, restricted access among key personnel, or disposal of confidential or protected health information in accordance with HIPAA.		

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

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

MEASURE 10.2.6:

Oversee grants and contracts.

Purpose & Significance

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

MEASURE 10.2.6:

Required Documentation 1

Guidance

Number of Examples
2 examples

Dated Within
5 years

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

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

Examples must be from two different program areas.

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

Documentation Examples

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

MEASURE 10.2.6:

Required Documentation 2

Guidance

Number of Examples
All, as appropriate

Dated Within
5 years

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

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

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

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

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

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

MEASURE 10.2.6:

Required Documentation 3

Guidance

Number of Examples
2 examples

Dated Within
5 years

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

The examples must be from two different areas.

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

Only one example can be with another health department.

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

Documentation Examples

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

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

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

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

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

MEASURE 10.2.7:

Manage financial systems.

Purpose & Significance

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

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

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

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

MEASURE 10.3.3:

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

Purpose & Significance

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

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

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

MEASURE 10.3.3: Required Documentation 3	Guidance	Number of Examples	Dated Within
		2 examples	2 years
3. Sharing information discussed by the governing entity or advisory board with all levels of health department staff.	The intent of this requirement is to foster awareness among staff at all levels of the health department about priorities, policy positions, opinions, or actions of the governing entity. Information flow about the governing entity's discussions facilitates knowledge among staff of the important issues facing the health department and public health practice, as well as its future. Staff at all levels will depend on the health department's organizational structure, generally consisting of frontline, mid-level, and leadership (managerial or supervisory) staff.		

MEASURE 10.3.3: Required Documentation 3	Guidance	Number of Examples 2 examples	Dated Within 2 years
	If the health department has multiple governing entities or entities serving in an advisory capacity, the health department may select and provide documentation for this requirement based on any one of those entities. **Documentation Examples** Documentation could include, for example, minutes from an all-staff meeting that included as an agenda item a summary of governing entity discussion; an email sent to staff describing governing entity discussions; or a notification to all staff about where they can find minutes from governing entity meetings on an intranet or website.		

MEASURE 10.3.4:

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

Purpose & Significance

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

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

Standards & Measures for Pathways Recognition, Version 2022

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