VERSION 2.0 WORK IN PROGRESS: Chronic Disease Think Tank Summary

February 26-27, 2020

The Public Health Accreditation Board is a 501(c)3 nonprofit organization dedicated to improving and protecting the health of the public by advancing and transforming the quality and performance of governmental public health agencies in the U.S. and abroad.

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The Public Health Accreditation Board (PHAB) held a Chronic Disease Think Tank on February 26-27, 2020 at the Task Force for Global Health in Decatur, GA. The purposes of the think tank were to review the current health department accreditation standards and measures related to chronic disease programs, interventions and strategies; to discuss any pertinent changes in public health practice related to chronic disease programs, interventions, and strategies and/or support for health departments work in this area; and, to recommend potential revisions in the accreditation standards and measures as PHAB prepares updates for its accreditation standards and measures.

Among the updates that were provided included information from Dr. Karen Hacker, Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention; a Public Health Practice Update which included the information from the NACDD Survey of States, the new Chronic Disease Competencies, and trends in chronic disease policy across the country by John Robitscher, Jean Alongi, Nancy Sutherland, and Liz Ruth from NACDD; perspectives from NACCHO by Bridget Kerner and from ASTHO by Alicia Smith. Think tank participants discussed health department performance on current PHAB standards and measures as well as practice changes since 2013 and projections for the future.

This document contains recommendations and overarching comments for PHAB to consider in Version 2.0 of initial accreditation and reaccreditation.

Overarching Recommendations for Proposed Changes to the PHAB Standards and Measures

Several pertinent areas were discussed that do not relate to a specific standard or measure. Those are included in the list below.

- PHAB should continue to consider that many health departments have lost resources, so they are not able to do as much as other health departments who have been able to access greater support for chronic disease prevention. This is also an area where different expectations for state health departments versus most local health departments would be in order.

- Alignment with the NACDD's STAR program would describe rapid cycle improvement processes for organizational capacity development to support chronic disease prevention and control. Six areas identified are evidence-based practice; leadership; management/administration; organizational climate and culture; partnerships and relationships; and workforce development.
- Leadership in chronic disease means that the health department is the "go-to" place for chronic disease expertise related to policy and surveillance and is similar to the chief health strategist role. There needs to be attention to how leadership is measured and how a health department documents leadership and leadership development; i.e., should it be addressed in the strategic plan, could documentation show that the health department leadership has been asked to participate in other sectors, could stakeholders assess the leadership?
- Alignment with current chronic disease best practices would require examples that included Alzheimer's and healthy aging, as well as opioids, in addition to the usual examples from chronic disease areas.
- Requiring examples from the area of chronic disease reflects the emphasis on prevention in public health and should be continued. There are chronic disease implications in many public health program areas (e.g., maternal-child health programs, environmental health) and across the community (e.g., the built environment), and in emergency preparedness.
- While consideration of best practices is important, health departments need to be encouraged to be innovative and develop initiatives that are specific to—or are tailored to meet the needs of—their populations (and not simply adopt "pre-packaged" programs).
- A concept of clinical connectedness to care was discussed as a role that health departments often play in chronic disease management. It was referred to the PHAB Public Health/Health Care Expert Panel for additional discussion.
- Some of the discussion focused on areas where other think tanks or expert panels had been completed. Those were:
    - Ensuring that workforce development includes professional development and competencies for chronic disease and/or health education practice, including the mid-level worker (who is generally more consistent and stays with the health department) and succession planning
    - Ensuring that that data/surveillance capacity includes data modernization for chronic disease surveillance and tracking
    - Ensuring strong partnerships with community organizations, including housing, transportation, and Medicaid providers
    - Ensuring a culture of improvement

Recommendations for Proposed Changes to the PHAB Standards and Measures

Domain 1

- Measure 1.1.2 – Clarify that the use of the data for decision-making is as important, if not more so, than where the data came from. Also clarify how residents of a community are involved – and not just partner organizations in the community. Look to the new National Academies of Medicine paper and PHAB's commissioned paper for additional clarification on meaningful community engagement.

Domain 3

- Measure 3.1.1, Required Documentation 1 – Consider adding, as a possible prompt for resources for evidence, the evidence-based resources that are cited in CDC Notice of Funding Opportunities (NOFOs). NOFOs often provide and cite the evidence and science that supports the activities and interventions being required. This will help HDs make connections between their funded activities and the evidence that supports interventions they are implementing. However, it would not be sufficient just to cite the NOFO; going to the source of the evidence would be more appropriate.
- Measure 3.1.1, Required Documentation 2 – Consider adding "selection, implementation, development, revision, or adjustment of educational materials/messages." Many health departments use off-the-shelf products, or products required by a grant, and therefore do not develop their own unique materials.
- Measure 3.1.1, Required Documentation 3 – Change the focus here to health education straies rather than message or materials. Switch the order with RD 2 above.
- Consider adding language that would give health departments credit for providing feedback to funders if specific materials are required by a grant. The feedback would reflect the feedback from the priority population with which the materials were used. For reaccreditation, PHAB could consider "testing" materials and using feedback from the priority population to make or suggest changes.
- 3.1.2 – adjust current language from "develop and implement" to "develop and/or implement" a health promotion strategy.
- Measure 3.2.6 – Update language and requirements to reflect intentional cultural sensitivity.

Domain 5

- PHAB should adjust the language and references related to Healthy People, in both the standards/measures document and the glossary, to be compatible with HP2030, to ensure alignment with the new version. When HP2030 launches the new website will include some updated definitions that can be used for alignment as well.

Domain 7

- Measure 7.1.1 – Recommend that PHAB remove any implication related to individual care and focus on a health equity vision that includes addressing social needs. Multi-sectoral work goes here, as does linkages to clinical care. The "buckets" of public health, health care, and social services may not be the right framework; health care and social services focus on individuals and public health focuses on the population.
- Measure 7.1.1- State health departments may have more responsibility for creating systems of care that ensure access while local health departments may work more with specific needs and providers. State health departments also often do work with state health insurance plans (as do some larger local health departments) and larger plans that cross local jurisdictional boundaries. System development is appropriate in this measure. Separate measures for state and local health departments are not needed, but options should be provided. State health departments and local health departments could work on any of them.

- Measure 7.1.3 – It was noted that this is a difficult measure for local health departments; their role is not clear. Clarify that partnerships with Medicaid are important here. Also, partnership with the health care system in preparing for and responding to disaster health care is relevant here. This is different than surge capacity; it's about disruptions in health care services. Additionally, documentation guidance could include examples of planning for women's health services if Planned Parenthood closes; if hospitals close clinics; or if a community loses a hospital, clinic, or service. PHAB should consider reducing the number of examples in Required Documentation 2 to one example, given the comprehensive nature of this work.
- Referred to the Public Health/Health Care Expert Panel – PHAB should develop a requirement for the health department to create/participate in creating systems of care during an outbreak such as Ebola or COVID19. All of this work could be a state/local collaboration.

Domain 11

- Refer to Administration/Management Think Tank requirements related to NACCHO's definition of organizational leadership. It might be difficult to document, but it is one of the key areas in chronic disease. Also, for this upcoming Think Tank, a requirement to have the capacity/competency to conduct cost effectiveness analysis or economic assessment of programs and services.

Recommendations Regarding Terminology and Definitions

Current Terms in PHAB Glossary	Existing Definition	Proposed Definition/ Recommendation/Notes
Barriers to Care	Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation. Barriers to care contribute to socioeconomic, racial and ethnic, and geographic differences in health care utilization and health status. (http://mchb.hrsa.gov/whusa11/hsu/downloads/pdf/303bcunc.pdf)	Clarify this definition to include invisible barriers to care as well.
Best Practices	Best practices are the best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices which may be defined as clinical or administrative practices for which there is considerable practice-based	No change

	evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence. (National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf)	
Chronic Disease	A chronic disease is a disease that has one or more of the following characteristics: it is permanent, leaves residual disability, is caused by a nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require long period of supervision, observation, or care. (Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009). Examples of chronic disease include heart disease, stroke, cancer, chronic respiratory diseases and diabetes. (World Health Organization (Switzerland). Health Topics: Chronic Diseases [online]. 2012 [cited 2012 Nov 7]. Available from URL http://www.who.int/topics/chronic_diseases/en/)	Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the US. Many chronic diseases are caused by a short list of risk behaviors: • Tobacco use and exposure to secondhand smoke. • Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats. • Lack of physical activity. • Excessive alcohol use. https://www.cdc.gov/chronicdisease/about/index.htm Add to examples in the documentation guidance mental health; emotional well-being; addiction; cognitive decline. It could also be noted that some infectious diseases

		cause chronic conditions, e.g., Lyme Disease and HIV.
Health Disparities	Health disparities are differences in population health status (incidence, prevalence, mortality, and burden of adverse health conditions) that can result from environmental, social and/or economic conditions, as well as public policy. These differences exist among specific population groups in the United States and are often preventable. (Adapted from: National Association of County and City Health Officials (US). *Operational Definition of a Functional Local Health Department [online]*. 2005 [cited 2012 Nov 8]. Available from URL http://www.naccho.org/topics/infrastructure/accreditation/OpDef.cfm. National Cancer Institute (US). *Health Disparities Defined [online]. 2010 [cited 2012 Nov 8] http://crchd.cancer.gov/disparities/defined.html*)	Ensure consistency with HP2030 when that definition is available
Health Education	Health education is any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conductive to good health. (Turnock, B.J. Public Health: What It Is and How It Works. 4th ed. Sudbury, MA: Jones and Bartlett; 2009.)	No change
Health Promotion	Health promotion is a set of intervention strategies that seek to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and	Health promotion is a set of intervention strategies that seek to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations

	work in partnerships that build on existing skills and strengths. Health promotion consists of planned combinations of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. Health promotion activities are any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities. (Turnock. Public Health: What It Is and How It Works (4th Ed). Jones and Bartlett. MA. 2009). Health Promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviors toward a wide range of social and environmental interventions.(http://www.whi.int/topics/health_promotion/en/) Health promotion approaches engage people and organizations in the transformation process, and their engagement in the process constitutes in itself a desired change (Institute of Medicine of the National Academies. An Integrated Framework for Assessing the Value of Community-based Prevention. The National Academies Press. 2012	that will improve or protect health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. Health promotion consists of planned combinations of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. Health promotion activities are any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities. (Turnock. Public Health: What It Is and How It Works (4th Ed). Jones and Bartlett. MA. 2009). Also, see WHO definition-health education is part of health promotion.
Non-infectious/ Non/communicable disease	Non-infectious/non-communicable diseases are conditions which affect the health status of populations, but which are not transmitted from one individual to another by micro-organisms. Non-communicable diseases represent the major causes of death and disability in most developed countries.	No change

	(Riegelman, R. *Public Health 101.* Jones and Bartlett. MA. 2010)	
Proposed New Terms		
Determinants of Health	None	Ensure consistency with HP2030 when that definition is available
Social Determinants of Health	Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. (World Health Organization (Switzerland). Health Topics: Social determinants of health [online]. 2012 [cited 2012 Nov 7].http://www.who.int/social_determinants/en/)	Ensure consistency with HP2030 when that definition is available. Need to clear about the difference between "determinants of health" and "social determinants of health." or do not use the determinants of health definition at all.
Social Needs	None	Ensure consistency with HP2030 when that definition is available.
Vulnerable Population Might want to use "High burden population" or "at risk" instead of "vulnerable"	A vulnerable population is a group of people with certain characteristics that cause them to be at greater risk of having poor health outcomes than the general population. These characteristics include, but are not limited to, age, culture, disability, education, ethnicity, health insurance, housing status, income, mental health, and race. (Adapted from: Institute of Medicine (US). Performance Measurement: Accelerating Improvement. Washington, DC: National Academies Press; 2006)	At-risk population refers to populations whose members may have different needs in different functional areas, including but not limited to maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from

		diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged. Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas: communication, medical care, maintaining independence, supervision, and transportation. In addition to those individuals specifically recognized as at-risk in the Pandemic and All-Hazards Preparedness Act (i.e., children, senior citizens, and pregnant women), individuals who may need additional response assistance include those who have disabilities, live in institutionalized settings, are from diverse cultures, have limited English proficiency or are non-English speaking, are transportation disadvantaged, have chronic medical disorders, and have pharmacological dependency. https://www.health.state.mn.us/communities/ep/afn/atriskdef.html

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		settings, are from diverse cultures, have limited English proficiency or are non-English speaking, are transportation disadvantaged, have chronic medical disorders, and have pharmacological dependency. https://www.health.state.mn.us/communities/ep/afn/atriskdef.html

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VERSION 2.0 WORK IN PROGRESS: Evidence Related to Chronic Disease

June 2020

The Public Health Accreditation Board is a 501(c)3 nonprofit organization dedicated to improving and protecting the health of the public by advancing and ultimately transforming the quality and performance of state, local, tribal, and territorial public health departments.

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This document represents findings from a scan of the literature related to activities health departments conduct to address chronic diseases. It is not meant to be an exhaustive search. It concludes with articles about the link between accreditation and chronic disease. If there are other resources on this topic of which you think PHAB should be aware, please contact Jessica Kronstadt at jkronstadt@phaboard.org.

Current State

It is evident that health departments prioritize chronic disease (CD) prevention and treatment. The Association of State and Territorial Health Officials (ASTHO) report an overall increase in the percentage of state health departments that listed chronic disease prevention as the top priority from 14.5% in 2014 to 23.9% in 2016.[1] The National Association of County and City Health Officials (NACCHO) Profile also indicates that many health departments screen for indicators of chronic disease, including 62% of local health departments screen for HIV/AIDS, 54% screen for high blood pressure, 53% screen for body mass index (BMI), 34% screen for diabetes cases, 32% screen for cancer cases, and 25% screen for cardiovascular diseases.[2]

Screening and treatment are key activities within chronic disease management that are nested within policy, systems, and environmental multilevel interventions centered around health equity.[3] Furthering health equity requires health departments to continue incorporating culturally competent strategies throughout partnerships, collaborations and organizational capacity building. Such strategies enable health departments to continue engaging in activities that tackle barriers pertaining to social determinants of health.

Effective implementation of these multilevel interventions requires health departments to develop organizational environments that are conducive to chronic disease management. Various studies note the following features as priority areas that facilitate these conducive environments.

Capacity Development

Priority practice areas must continuously be improved. One way to engage in improvement is through the use of STAR, a tool developed by Jay Galbraith and adapted by the National Association of Chronic Disease Directors that specifically focuses on chronic disease management. STAR stands for state activation and response and is an "opportunity for continuous capacity development through rapid cycle improvement process for organizational capacity development."[4] This tool

defines its organizational framework into six pieces: workforce development, evidence-based public health practice, leadership, management and administration, organizational climate and culture, and partnerships and relationships. Each of the six pieces are aligned with the twelve PHAB domains. A total of twenty-one states and territories utilize this tool.

Workforce and Evidence-Based Public Health

The use of evidence-based approaches is key to addressing chronic disease.

- One study suggests utilizing competencies to promote effective public health practice and chronic disease prevention and control since practitioners may not be coming from a public health background. This study notes using the competencies for chronic disease practice "highlights interrelationships among the specific skills and knowledge required for leading and managing state chronic disease programs." Additionally, the competencies are in line with priorities outlined by key agencies such as the US Public Health Service, Centers for Disease Control and Prevention, and the Institute of Medicine.[5]
- Barriers related to training, resources, time, funds, and management buy-in make it challenging for practitioners to use EBPH. A lack of training in finding, using, and evaluating evidence-based interventions (EBI) and a lack of a foundational understanding in biostatistics and epidemiology deters practitioners from adapting EBI for their respective jurisdictions. However, practitioners also noted they do not have time to learn EBIs. Funding constraints and barriers in obtaining buy-in from management also make it difficult to engage in utilizing EBIs.[6]
- However, solutions such as increasing funding to include evidence database subscription fees allow practitioners to have digital access to literature which encourages the use of EBPH.[7] Additionally, buy-in from leadership, work culture and communication are factors that facilitate an environment that uses EBPH.[8]

Health Equity and Social Determinants of Health

Chronic disease approaches must be centered around the principle of health equity.

- LHD work units with a strong commitment to achieve health equity "were more likely to encourage the use of evidence-based decision making (OR: 2.6) and to be perceived as capable of leading such decision making." These units tend to incorporate health equity throughout their work by building trust with the target populations, utilizing epidemiology and various methods of evaluations to find the gaps in health outcomes, and tailor EBI to close those gaps.[9]
- Additionally, these units tended to have strong, effective leadership as well as strong, diverse collaborations and partnerships. Another project identified reducing health inequities as a core value and incorporated approaches such as selecting subgrantees from populations and jurisdictions with poor health outcomes, supporting community coalitions and engaging in community mobilization.[10]
- The study recommended implementing policies that enable training on best-practice models and approaches, structuring units to incorporate health equity rather than separating it into one unit, drawing on existing programs to form diverse partnerships, engaging different stakeholder groups and aligning funding with community organizations that work with underserved groups.9

Partnerships

- Eighty-four percent of state health agencies indicated they are part of one or more formal partnerships in general. 88% of local public health agencies noted collaborating with health care entities including hospitals, medical groups, community health centers, insurers as well as educational institutions (primary, secondary, universities, medical schools), and law enforcement for information exchange. There has been an increase in collaboration with

health insurers due to implementation of the HiTECH Act, Affordable Care Act, as well as state and federal regulations and the All-Payer Claims Database (APCD).1

- Partnerships with local universities allow practitioners to access resources through universities. Additionally, partnerships with local organizations outside of the health sector including transportation and religious organizations can be instrumental in tailoring EBPH in the respective communities they serve. LHDs should maintain and establish these partnerships through a dedicated point person.7
- One study found that policy, systems, environment and infrastructure (PSEI) change is best done in a dyad, or a partnership between a backbone organization that provides technical assistance, expertise, and funding aligned with the PSEI change, and an organization with readiness for change and a staff champion with sectoral knowledge. The study found that the champion is key in helping the organization move toward change and the backbone organization's relationships and partnerships with multiple sectors is what allows for the dyad.10 Additionally, findings indicate close, trusting relationships support the coaching model built around the dyad.

System Structure and Performance

- Success factors in the implementation of the Coordinated Chronic Disease Program indicate that that supporting strong program infrastructure hinges on consistent communication and messaging.11 "States with well-articulated theories of change reported less difficulty communicating with purpose + goals of an integrated approach of staff and stakeholders."[11]
- Internal communication can be greatly impacted by the layout or location of different chronic disease programs within LHDs.11 Chronic disease programs housed on the same floor were found to have improved communications and collaborations.12
- Additionally, one state's cross-chronic disease leadership team was found to improve internal communication.12 The leadership team needs to communicate to decrease internal resistance and concern over potential loss of disease-specific focus.
- Another project found that, "coordination of services across chronic disease conditions represents prime opportunity for public health programs to increase sustainability of their program by reducing spending and improving service delivery."12

Information and Technology

- One study found that harnessing electronic health records (EHRs) for chronic disease surveillance can increase use of evidence-based decision-making. Similarly, findings from another study found that a regional EHR-based public health surveillance with distributed data networks improves representativeness of the population and can help LHDs assess across continuum relevant for LHD planning.[12]
- Additionally, utilizing electronic health records containing data from large information systems such as vital records and hospital discharge data allow for enhanced chronic disease monitoring.[13]

Chronic Disease and Accreditation

One study that included interviews with state chronic disease directors found that accreditation was an impetus for evidence-based practice.[14] Similarly, a survey of local health department chronic disease directors found a significant relationship between accreditation and having higher capacity for evidence-based decision making.[15] Another study found that accreditation is associated with increased likelihood of including an evidence-based active transportation strategy in the community health improvement plan.[16] Local health department engagement in policy work to address obesity is also associated with accreditation.[17]

Meaza Belachew compiled this scan as part of an internship for PHAB.

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VERSION 2.0 WORK IN PROGRESS: Chronic Disease – What Have We Learned from Accredited Health Departments?

February 2020

This document summarizes what PHAB has learned about how health departments (HDs) participating in accreditation are addressing chronic disease-related activities. In particular, it focuses on the reasons that HDs struggled with measures that relate to chronic disease. It is important to note that these measures were selected because they are relevant to chronic disease (e.g., they might require that one of the examples relate to a chronic disease program). However, they are broader than chronic disease. Therefore, health departments may have been assessed as Slightly or Not Demonstrated (SD/ND) on these measures for reasons unrelated to their chronic disease programming.

It also includes findings from an analysis of accredited health departments' community health improvement plans (CHIP) and a list of population health outcomes health departments are tracking in their communities.

Below is a summary of the distribution of assessments for related measures. These data are for 179 HDs assessed under Version 1.0 and 158 HDs assessed under Version 1.5 of the Standards & Measures.

Measure	%Fully Demonstrated	%Largely Demonstrated	%Slightly Demonstrated	%Not Demonstrated	N
1.1.2 (ver 1.0)	43.6%	49.2%	7.3%	0.0%	179
1.1.2 (ver 1.5)	12.0%	61.4%	26.6%	0.0%	158
2.1.1	68.2%	23.1%	7.4%	1.2%	337
2.1.3	89.3%	5.0%	3.0%	2.7%	337
3.1.1	46.0%	41.5%	12.2%	0.3%	337
3.1.2 (ver 1.0)	54.7%	31.8%	11.2%	2.2%	179
3.1.2 (ver 1.5)	28.5%	51.3%	19.6%	0.6%	158
3.1.3 (ver 1.5)	39.2%	37.3%	21.5%	1.9%	158
3.2.3 (3.2.2 in ver 1.0)	48.1%	41.2%	9.8%	0.9%	337
3.2.5 (3.2.4 in ver 1.0)	80.7%	18.1%	1.2%	0.0%	337
3.2.5 (ver 1.0, similar to 3.2.6 in ver 2.0)	69.3%	28.5%	1.7%	0.6%	179
3.2.6 (ver 1.5)	62.0%	35.4%	2.5%	0.0%	158
4.1.1 (ver 1.0)	86.6%	11.2%	2.2%	0.0%	179
4.1.1 (ver 1.5)	44.3%	52.5%	2.5%	0.6%	158
5.2.2 (ver 1.0)	51.4%	37.4%	11.2%	0.0%	179
5.2.2 (ver 1.5)	31.0%	53.2%	14.6%	1.3%	158
7.1.1 (ver 1.0)	69.8%	20.7%	7.8%	1.7%	179
7.1.1 (ver 1.5)	29.7%	42.4%	26.6%	1.3%	158
7.1.3 (ver 1.0)	53.1%	27.9%	19.0%	0.0%	179
7.1.3 (ver 1.5)	33.5%	35.4%	29.1%	1.9%	158
10.1.1	74.5%	17.5%	5.6%	2.4%	337
11.1.3 (ver 1.0, similar to 11.1.4 in ver 1.5)	53.6%	40.8%	5.6%	0.0%	179
11.1.4 (ver 1.5)	45.6%	48.7%	5.1%	0.6%	158

Data are presented separately for health departments assessed under Version 1.0 and Version 1.5 of the Standards & Measures if there was a substantive change in the requirements. If the two versions are

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substantively the same, the aggregate data are presented. The numbering of some of the measures changed between Version 1.0 and Version 1.5. (For example, the measure about the communication procedures plan was 3.2.2 in Version 1.0 and 3.2.3 in Version 1.5.)

To better understand HDs' performance on these measures, PHAB conducted an analysis of the conformity comments of HDs that were assessed as Slightly or Not Demonstrated (SD/ND) in at least 5% of the Site Visit Reports. The results of those analyses are shown below. For each measure, the most common reasons for the assessment are listed, including the number of HDs for which that reason was indicated. One HD could have multiple reasons listed. The reasons are linked to specific required documentation (RD) listed in the PHAB Standards & Measures. For reference, please see: https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf.

Measure 1.1.2: A state/Tribal/local community health assessment
Of the 55 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD 2: Opportunity for community to provide input into assessment (44 HDs)
- RD 2: Sharing of preliminary findings with community (32 HDs)
- RD 1: Discussion of inequities/disparities* (28 HDs)
- RD 1: Consideration of factors that contribute to higher health risks and poorer health outcomes in specific populations* (25 HDs)
- RD 1: Description of community assets (20 HDs)
- Complete date within the time period (17 HDs)
- RD 3: Neighborhood/community specific analysis* (13 HDs)
- RD 1: Outcomes in specific populations* (12 HDs)
- RD 3: Ongoing monitoring* (12 HDs)
- RD 1: Adequate description of the demographics of the population (11 HDs)
- RD 3: Engagement/link to community identified in CHA as part of ongoing monitoring* (11 HDs)
- RD 1: Description/distribution (10 HDs)

** Added in Ver 1.5*

Measure 2.1.1: Protocols for investigation process
Of the 29 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1b: Protocol steps that include timelines (13 HDs)
- RD1a: Assignment of responsibilities (11 HDs)
- Date that meets measure requirements (10 HDs)
- RD1b: Protocol that includes investigation steps (10 HDs)
- Protocol that comprehensively covers diseases and environmental health issues (8 HDs)
- RD1b: Protocol that includes reporting requirements (8 HDs)

Measure 2.1.3: Capacity to conduct investigations of non-infectious health problems, environmental, and/or occupational public health hazards
Of the 19 HDs assessed as SD/ND, the most common challenges with documentation were:

- Documentation was not about investigation of a hazard (11 HDs)
- Insufficient evidence of HD's role (5 HDs)

Measure 3.1.1: Information provided to the public on protecting their health
Of the 42 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD2: Consultation with community & target group in developing materials (30 HDs)
- RD3: Messages coordinated with other HDs or community partners (21 HDs)
- RD1: Cultural competence & health literacy taken into account (18 HDs)
- RD1: Distribution of the information (13 HDs)
- RD2: Social and environmental factors addressed (13 HDs)
- RD1: Indication of target audience (12 HDs)
- RD2: Community and target group involvement for the purpose of developing the messages and materials (11 HDs)

Measure 3.1.2: Health promotion strategies to mitigate preventable health conditions
Of the 56 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD3: Solicitation of review, input, and/or feedback from the target audience during the development of the health promotion strategy (40 HDs)
- RD4: Collaboration with partners in implementing strategy (36 HDs)
- RD2: Use of various marketing or change methods (30 HDs)
- RD2: Strategies are evidence-based, rooted in sound theory, practice-based evidence, and/or promising practice (24 HDs)
- RD2: Engagement of community and target audience in development of strategy (21 HDs)
- RD2: Strategy includes a focus on social and environmental factors (16 HDs)
- Articulation of a strategy throughout the documentation (14 HDs)
- RD2: Planned collaborative implementation (13 HDs)
- RD3: Consistent use of program examples across RDs (12 HDs)
- RD1: Planned approach for developing health promotion programs (11 HDs)
- Evidence of implementation (11 HDs)
- Priorities identified through health improvement plan (requirement in Ver 1.0 of S&M only) (10 HDs)

Measure 3.1.3: Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes (Measure added in Version 1.5)
Of the 37 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- Element c: Internal policies and procedures to ensure programs address specific populations (22 HDs)
- Element b: Plans/efforts to address social change, social customs, community policy, level of community resilience or the community environment (17 HDs)
- Element a: Analysis of factors that cause or contribute to health equity (12 HDs)
- Element a: Analysis of health equity (11 HDs)

Measure 3.2.3: Communication procedures to provide information outside the health department
(3.2.2 in Version 1.0)
Of the 36 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1: Dissemination of accurate, timely, appropriate information for different audiences (25 HDs)
- RD1: Coordination with community partners for communicating messages (18 HDs)
- RD1: Description of responsibility of staff positions that interact with news media and public (16 HDs)
- RD2: Implementation of communications procedures (13 HDs)
- RD1: Indication of when contact list used and how maintained (12 HDs)
- RD1: Contact list of media/key stakeholders (11 HDs)

Measure 5.2.2: State/Tribal/local health improvement plan adopted as a result of the health improvement planning process
Of the 45 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD1d: Alignment w/state, national, or local priorities (30 HDs)
- RD1b: Policy changes needed to accomplish health objectives (in ver 1.5 these must address inequities) (27 HDs)
- RD1a: Measurable outcomes or indicators of health improvement (in ver 1.0 this was RD1d) (22 HDs)
- RD1c: Specific designation of individuals and organizations that have accepted responsibility for implementing strategies (20 HDs)
- RD1a: Time-framed targets (17 HDs)
- RD1a: Consideration of social determinants of health (added in ver 1.5) (14 HDs)
- RD1a: Address inequities (added in ver 1.5) (11 HDs)

Measure 7.1.1: Process to assess the availability of health care service
Of the 61 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:

- RD2: Data shared for the purposes of assessing the availability of health care services and for planning (23 HDs)
- RD1: Collaborative process relates to access of care (21 HDs)
- RD3: Consideration of emergent issues with the same collaborative described in RD1 (added in ver 1.5) (21 HDs)
- RD2: Sharing of data relates to access to care (20 HDs)
- RD2: Sharing of data with the same collaborative described in RD1 (19 HDs)
- RD2: Evidence of sharing data (16 HDs)
- RD3: Addresses emerging issue that will impact services (added in ver 1.5) (16 HDs)

Measure 7.1.3: Identification of gaps in access to health care services and barriers to the receipt of health care services identified
Of the 83 HDs assessed as SD/ND, the most common challenges were deficiencies in documentation that demonstrated:
- RD2a: Assessment of capacity and distribution of health care providers (53 HDs)
- RD2b: Availability of healthcare services (49 HDs)
- RD2c: Identification of causes of gaps in services and barriers to receipt of care (48 HDs)
- RD2d: Results of data gathered periodically concerning access (43 HDs)
- RD2: Analysis/conclusions to develop strategies (26 HDs)
- RD1: Process specific to gaps in access (i.e., documentation was of CHA process rather than of process related to access gaps) (added in ver 1.5) (12 HDs)
- RD1: Identification of parties involved (added in ver 1.5) (12 HDs)
- RD2: Provision of 2 examples (10 HDs)

Measure 10.1.1 -Applicable evidence-based and/or promising practices identified and used when implementing new or revised processes, programs, and/or interventions
Of the 27 HDs assessed as SD/ND, the most common challenges with documentation were:
- Out of PHAB's scope of authority (16 HDs)
- Evidence base not applied to implementing new or revised processes, programs, or interventions (16 HDs)
- Out of Timeframe/No date (6 HDs)
- Source of evidence base not cited (6)

Measure 11.1.4: Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes (ver 1.5 only)
Of the 12 HDs assessed as SD/ND, the most common challenges with documentation were:
- RD1: Health inequities incorporated into the development interventions and materials (8 HDs)
- RD2: Processes, programs, or interventions provided in a culturally or linguistically competent manner (5 HDs)

Community Health Improvement Plans
PHAB reviewed the CHIPs submitted by 320 accredited HDs (including the health departments accredited as part of the centralized state integrated local public health department system in Florida) and extracted and then categorized the indicators they are using to track progress towards health improvement in their jurisdictions. Among those CHIPs, 85% had at least one indicator related to Nutrition, Physical Activity, and Obesity. Specifically, 50% had one or more indicators related to obesity rates. Other indicators focused on:
- Individual behavior:
  - Physical activity/inactivity levels (43%)
  - Healthy eating patterns (31%)
- Physical environment:
  - Access to healthy food (39%)
  - Access to exercise opportunities (30%)

The following are other chronic disease related indicators that appeared in at least 10% of the CHIPs:

- Tobacco use (38%)
- Diabetes (12%)
- Poor mental health days (12%)

Because social determinants of health play a central role in chronic disease, it is also worth noting that about half the CHIPs had at least one indicator related to social environment.

Population Health Outcomes Tracking

As health departments apply for reaccreditation, they are required to indicate the population health outcomes they are tracking in their community. The graph below represents all the chronic-disease related indicators that were selected by 50% or more of the 52 health departments that had reported their population health outcomes as of early February 2020.