Public Health Accreditation Board

Public Vetting Draft of Version 2022 Standards & Measures for Foundational Capabilities and Potential Use in Pathways Recognition Program

September 2021

This document contains a list of Measure that **could** be included in the Pathways Recognition Program. However, it is possible that the Pathways Program will include only some of the Measures in this document. It is also possible that other Measures from Version 2022 will be included in the Pathways Program.

The Measures in this document are aligned with the Foundational Capabilities of the Foundational Public Health Services (FPHS) framework. That framework identifies seven capabilities to describe the infrastructure needed for all health departments to provide public health protection and to provide fair opportunities for all to be healthy. In Version 2022, you will see which Measures correspond to one of the following seven capabilities: 1) Assessment/Surveillance, 2) Emergency Preparedness and Response, 3) Policy Development and Support, 4) Communications, 5) Community Partnership Development, 6) Organizational Administrative Competencies and 7) Accountability/Performance Management. Details about the Foundational Capabilities can be found here. The Accreditation Standards & Measures includes additional requirements in these areas to further advance public health practice. Consistent with previous versions of the PHAB Standards & Measures, the measures are aimed to foster continuous improvement and stretch, while still being attainable for health departments. PHAB has identified Foundational Capabilities Measures for both initial accreditation and reaccreditation; however, this document only includes those requirements for initial accreditation.

Here are a few things to note about the Standards & Measures:

- All of the elements that a health department must document are now contained in the Required Documentation column. The Guidance column includes additional examples and suggestions to help health departments consider potential documentation to submit.
- Requirements related to preparedness (Standard 2.2) have evolved based on lessons learned during the COVID-19 pandemic and to better align with NACCHO's Project Public Health Ready and the CDC's Operational Readiness Review process for Public Health Emergency Preparedness (PHEP) grantees.

Please note, this document includes the Standards & Measures for Foundational Capabilities. If you are looking for Standards & Measures for Initial Accreditation or Reaccreditation, see the Version 2022 webpage.

Domain 1
Assess and monitor population health status, factors that influence health, and community needs and assets.

Standard 1.1
Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

Measure 1.1.1 A: Develop a Tribal/local/state community health assessment.
Foundational Capability Measure

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 Tribal, state, or local community health assessment tells the community story and provides a foundation for efforts to improve the health of the population. It is the basis for priority setting, planning, program development, funding applications, policy changes, coordination of community resources, and new ways to collaboratively use community assets to improve the health of the population. A community health assessment provides the general public and policymakers with information on the population's health, the broad range of factors that impact health, and assets and resources available to address health issues and their contributing factors. 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 are not limited to traditional public health data but may also include information about 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 and collected through various data collection methods.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Community health assessment (CHA) that must include **all** of the following elements: a. A description of the collaborative process for developing the CHA. b. A list of participating partners involved in the CHA process. Participation must include:	For required element a: The intent of element a is to describe the collaborative process used among partners to assess the health of the community. This could be included within, for example, the health assessment, partnership charter, provided as a description, etc. The process could describe the timeline, how partners engaged (e.g., meetings or other methods of convening partners, or use of engagement strategies such as stakeholder analysis, power mapping, etc.) and how data were assessed to draw conclusions about health issues and needs. 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	1 community health assessment	5 years

i. At least 2 organizations representing sectors other than public health. ii. At least 2 community members or organizations that represent populations that are disproportionately affected by health risks or poorer health outcomes. c. Comprehensive, broad-based data. Data sources must include: i. Primary data addressing at least one population group or topic area. ii. Secondary data from two or more different sources. d. A description of the demographics of the population served by the Tribal/local/state 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.	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 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. Examples of 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), the University of Kansas Community Toolbox, etc. For required element b: Partners that represent various sectors of the community could include, for example: hospitals and other health care providers; local Childhood and Women's Death Review organizations; environmental public health groups; community foundations and philanthropies; volunteer organizations; religious organizations; community organizers and advocates; real estate representatives; local or state government (such as, elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.); businesses and industries; the chamber of commerce; academic institutions; etc. To empower individuals to participate in the assessment—and ultimately the improvement—of health in their jurisdictions, the partnership may include community members. Individuals or organizations that represent populations that are disproportionately affected by higher health risks or poorer health outcomes could include, for example: groups that represent minority health, historically excluded or marginalized population groups, aging populations (e.g., local, state, and/or regional aging networks and agencies), not-for profits (such as local branches/affiliates of disease specific or issue specific advocacy groups), civic groups representing specific sub-populations, etc. The documentation will include either organizational affiliations or will indicate if individuals are community member representatives. Partners in the community health assessment 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/near the health department's jurisdiction, etc. 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 (such as environmental health; health care programs; or mental health programs). 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		

e. A description of health challenges experienced by the population served by the health department, based on analyses of data listed in element (c) above, which must include disparities between subpopulations or sub-geographic areas in terms of: i. Health status. ii. Health behaviors. f. A description of inequities in the factors that contribute to health status or behaviors (element e), which must, at minimum, include: i. Social determinants of health. ii. Built environment. g. A listing of community assets or resources that can be mobilized to address health challenges. The list must include assets or resources from sectors beyond healthcare and the health department.	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. For required element c: Primary data are data for which collection is initiated or guided by the health department or CHA partnership. Data collection methods could include, for example, asset mapping, community/town forums, community listening sessions, surveys (such as surveys of high school students and/or parents), focus groups (such as sessions discussing community health issues), or other data that the health department/CHA partnership collects to better understand health challenges, contributing factors, or assets. 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 to identify environmental (including the built environment) health challenges (e.g., photovoice) 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, Tribal, state, and local data (not collected by, or on behalf of, the health department/CHA partnership). Specific secondary data sources could include, but are not limited to, Behavioral Risk Factor Surveillance Survey (BRFSS)/Youth Risk Behavior Surveillance (YRBSS) (if data collection is not initiated or guided by the health department or CHA partnership), County Health Rankings, CDC Disability and Health Data System, US Census American Factfinder, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, PH WINS, and/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, insurance claims and Electronic Health Record (EHR) data; local and state chart of accounts; data from local schools, academic institutions, or other departments of government (for example, recreation, public safety, etc.); community not-for-profits [for example, Aging and Disability Resource Centers (ADRCs)], 211 data, or other sources of nontraditional community; and environmental health indicators, such as housing, transportation, walkability/green space, agriculture, labor, and education. 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 or to health care), educational attainment, home		

	ownership, employment status, immigration status, sexual orientation, etc. For required element e: The intent of element e is to present a summary of themes and findings based on the data in element c, above. Disparities could include, for example, analysis of differences in rates of illness, death, chronic conditions, behaviors (e.g., smoking/vaping rates, high-risk sexual behavior), 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). A table, or cross-tabulation, that demonstrates differences in chronic disease morbidity by race and ethnicity; or a map showing poorer health outcomes by zip code are some specific ways in which this could be presented. 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. Examples could include, for example, a description of health inequalities based on differing availability of grocery stores in specific neighborhoods; differences in the built environment or walkability; differences in transportation routes as it relates to access to health care services in the jurisdiction. This analysis could also consider the disproportionate effects of climate change on subpopulations. 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, insurance status, etc.) and consider 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, which **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 health equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes. For required element g: Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, etc. Intangible assets and resources could also be included, for example, community leadership, examples of social		

	cohesion, and social capital. 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 that continuously update data content) are acceptable, if they contain elements a-g. 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.		

Standard 1.2
Collect and share reliable and valid data that provide information on conditions of public health importance and on the health status of the population.

Measure 1.2.1 A: Collect primary non-surveillance data.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's capacity to collect or initiate/guide the collection of primary data concerning health; 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. Primary data collection efforts can capture differing population perspectives, help identify priorities, and inventory community resources that can be mobilized to address situations that contribute to higher health risks or poorer health outcomes. 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Primary quantitative population health data collected for the purposes of understanding health status in the jurisdiction, including: a. Data collection instruments.	Surveillance data, program evaluation, and customer satisfaction do **not** meet the intent of this measure. Data collection instruments are standardized tools from the standpoint that the same tool was 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.	2 examples	5 years

b. Findings based on the collection of data using those instruments. Data must provide information about the health status of the population or the factors contributing to the health status.	Primary quantitative data could be obtained from surveys of target groups (e.g., teenagers, jobless individuals, residents of a neighborhood with higher risks of poor health outcomes). **DOCUMENTATION EXAMPLES** Documentation could be, for example, copies of data collection instruments used **and** corresponding reports or presentations of key findings; copies of meeting minutes showing briefings or summaries of findings; or other evidence showing findings based on use of standardized data collection instruments.		
2. Primary qualitative population health data collected for the purposes of understanding health status in the jurisdiction, including: a. Data collection instruments. b. Findings based on the collection of data using those instruments. 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.	Program evaluation and customer satisfaction data do **not** meet the intent of this measure. Data collection instruments are standardized tools from the standpoint that the same tool was used with all respondents. For example, an interview or focus group guide used with a representative sample of potential respondents could be used. 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, key informant interviews, etc. **DOCUMENTATION EXAMPLES** Documentation could be copies of data collection instruments used **and** corresponding reports or presentations of key findings; copies of meeting minutes showing briefings or summaries of findings; or other evidence showing findings based on use of standardized data collection instruments.	2 examples	5 years

Measure 1.2.2 T/L: Participate in data-sharing with other entities.
Foundational Capability Measure

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 the health department, health care, education, criminal justice, transportation, social services, etc.). Sharing and receiving data are key steps in generating a better understanding of health within the jurisdiction.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Participation in data sharing with other entities, by either: a. Providing data to another entity; OR b. Receiving data from	The intent of the requirement is to demonstrate sharing or receiving data that can be used to gain new insights. 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 a row with multiple data points for each unit (i.e., each individual, jurisdiction, or clinic, etc.) in the dataset, which would enable the recipient of those data to conduct analyses or look for relationships	2 examples	2 years

another entity; OR c. Providing a data use agreement with another entity. The data being shared must include record-level data. For this measure, the examples **cannot** demonstrate data sharing with a local health department's respective state health department.	among the data points. 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 (such as, relationships between disease prevalence and the patients' zip code or demographics). The entity could be, for example, an organization, an individual, another local or Tribal health department, etc. 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. Submitted or received data could also be shared outside of a data system, such as providing environmental public health data through email. For Tribal health departments, 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 with the state or other entities. **DOCUMENTATION EXAMPLES** Documentation could be, for example, emails, screen shots documenting data were shared/received through web pages or a portal, data use agreements, etc.		

Measure 1.2.2 S: Facilitate data-sharing with health departments and other entities.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in participating in statewide data systems, as well as processes for sharing data with Tribal and local health departments and other entities. States maintain data systems (e.g., statewide registries, vital records systems) that are critical for capturing information about the health of the state. State health departments should aid Tribal and local health departments in providing accurate and timely data as part of these systems. To facilitate use of these data throughout the state, the state health departments should have mechanisms through which Tribal and local health departments can access data generated through those systems. In addition, state health departments have access to and compile data that are not available to Tribal and local health departments and other entities and should have a process in place to share those data.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Data provided to Tribal and local health departments based on statewide data systems in which the Tribal and local health department participates.	Tribal or local health departments report data into statewide systems (e.g., registries, or vital records or surveillance systems). Receiving data back from those systems allows for greater use in planning and action at the local level. **DOCUMENTATION EXAMPLES**	2 examples	5 years

One example must be with a Tribal health department if one exists in the state. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the coversheet and two examples with local health departments must be provided.	Documentation could be, for example, data from an immunization registry showing the data from a local or Tribal health department's jurisdiction, accompanied by documentation of the data's distribution to that health department. Alternatively, documentation could be a summary of data from the vital records systems that shows birth data for each county in the state, accompanied by evidence of documentation it was distributed to all county health departments. If the data are available in a portal that local and Tribal health departments have access to, the documentation could be a screenshot of that system, accompanied by an email, meeting minutes, or other evidence that the state health department has explained to other jurisdictions how they can access the portal.		
2. Tribal and local health departments asked about what support or technical assistance is needed to enable their participation in statewide data systems. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the coversheet and two examples with local health departments must be provided.	**DOCUMENTATION EXAMPLES** Documentation could be, for example, emails, phone call minutes, newsletters, memos, meeting minutes, or results of a survey with questions designed to understand the needs and participation among Tribal and local health departments in statewide data systems. These can include statewide registries, vital records, surveillance systems, etc. This would also include efforts for the state to get feedback from local/Tribal health departments about system modifications that would make the system more usable or the engagement of local/Tribal health departments in the development of new systems to ensure their feedback is reflected in requirements.	2 examples	5 years
3. Support or technical assistance provided to Tribal and local health departments to be responsive to their needs concerning participation in statewide data systems. One example must be with a Tribal health department, if one exists in the state. If there is not a Tribal health department in the state—or if no Tribal health departments participate in statewide data systems—this must be indicated in the coversheet and two examples with local health departments must be provided.	State health departments play a critical role in ensuring Tribal and local health departments understand their access to and use of statewide data systems. Technical assistance and support provided could include, for example, guidance on access to statewide data system software application licenses, support using or uploading data into statewide data systems, guidance about the most effective ways to download and present data from the statewide system, or assistance with using data visualization websites that include representations of the data from those systems. Providing access to data systems, alone, would **not** meet the intent of this requirement. The state health department **cannot** use examples of providing assistance to program divisions within the state health department's central office. In a centralized system, the examples could be assistance to staff serving local jurisdictions. This could be related to the activities described in Required Documentation 2, but it does not need to be. The state may not be able to meet all requests. The aim is that state,	2 examples	5 years

	Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful. **DOCUMENTATION EXAMPLES** Documentation could be, for example, newsletters, memos, meeting minutes, phone call minutes, or software license agreements with emails showing assistance to support use of statewide data systems. Documentation or the description in the coversheet will indicate how the support is responsive to Tribal or local health department needs. An assessment of needs or formal request for support is not required. The coversheet could describe, for example, a request for assistance made by the Tribal or local health department on a phone call or through an email.		
4. A data use process that includes: a. A description of how the health department makes data and supporting materials available to others upon request. b. The process used to ensure requests receive responses. This process must pertain to data requests from both other health departments and from other individuals or organizations.	The intent of the requirement is to demonstrate that the state health department has a process in place to ensure data are made available to health departments and other individuals or organizations when requested. The policy or procedure should address how the state health department monitors and tracks which data requests are outstanding or have been resolved. For required element a: The policy or procedure may be included as part of a larger set, or standalone document. The policy or procedure will address data requests, beyond public or open record requests. Supporting materials will include information necessary to help the recipient use the data and could be, for example, a data dictionary, a codebook, or an FAQ about the data. The policy or procedure is **not** required to include a comprehensive list of supporting materials available, but could describe, for example, the types of supporting materials or the process for making sure appropriate materials are available. For required element b: The process to ensure the requests are resolved might address how the tracking log is maintained and used.	1 policy or procedure	5 years

Standard 1.3
Analyze public health data and share and use the results to improve population health.

Measure 1.3.1 A: Analyze data and draw public health conclusions.

Foundational Capability Measure
Purpose & Significance The purpose of this measure is to assess the health department's capacity to analyze data and to draw conclusions to increase understanding of, for example, health problems, behavioral risk factors, environmental public health hazards, and social and economic conditions that affect the public's health. Analysis of data is important for assessing the contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions of a health problem. Data analysis is critical for problem identification, program design, and evaluation of programs for 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.

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
1. Data analyzed, which includes: a. The analytic process used in the data analysis. b. Comparisons. c. Key findings drawn from the data analysis and comparisons. One example must be the analysis of qualitative data and one must be the analysis of quantitative data. The key findings must include at least some data specific to the population served by the health department or a subset of the jurisdiction's population.	The intent of this requirement is to provide key findings based on analysis, **not** to just collect or present data. Evidence of the health department's analysis and conclusions drawn based on the analysis is required for this measure, but the actual data set(s) used in the analysis do **not** need to be provided. The data analysis may point out 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 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, Behavioral Risk Factor Surveillance Survey (BRFSS) data, youth survey data (e.g., YRBSS), vital statistics, workplace fatality or disease investigation results, outbreak investigation results, social determinants, 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, focus group data, after action reports, hospital data, or not-for-profit organizations' data (for example, poison control center data). For required element a: Analytic processes for quantitative data could be, for example, crosstabs, tests of significance (T-test, chi-square, ANOVA), or regression analysis. Analytic processes for qualitative data could be, for example, content analysis or thematic coding. The analytic process (element a) can be described on the coversheet. For required element b:	2 examples	Analysis conducted within 5 years (data may be older)

	Comparisons could be from within the same data collection effort—in other words, if a health department conducted a focus group with pre-teens and another with teenagers, the comparison of the qualitative data could reflect different themes across those focus groups. Comparisons that can be used as part of the analysis 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 (for example, 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, etc.). For required element c: Key findings could include, for example, a narrative highlighting conclusions based on the data analysis and what those findings indicate in relation to the groups/factors used for comparison in element b, above.		

Domain 2
Investigate, diagnose, and address health problems and hazards affecting the population.

Standard 2.1
Anticipate, prevent, and mitigate health threats through surveillance, and investigation of health problems and environmental hazards.

Measure 2.1.1 A: Maintain surveillance systems. **Foundational Capability Measure**
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 and data can serve as an early warning system for impending public health emergencies; document impact of interventions; track progress toward specified goals; monitor and clarify epidemiology of health problems; facilitate priority setting; and inform public health policy and strategies. (World Health Organization)

Required Documentation	Guidance	Number of Examples	Dated Within
1. Process(es) or protocol(s) for collection and analysis of public health surveillance data. Process(es) and protocol(s) must include: a. How data are collected from multiple sources 24/7. b. What data quality control measures are in place. c. How data are analyzed to identify deviations from expected trends. d. How data are disaggregated by sub-population. e. Which surveillance data are considered to be confidential. f. How confidential data are maintained in a secure and confidential manner. g. How the system to collect data is tested including the frequency of system tests. If this function is carried out in full by a federal agency, other health department, or other entity, then an MOU/MOA or other formal agreement, **must** be provided to demonstrate the formal assignment of responsibilities for collection 24/7, quality control, analysis of surveillance data, and how confidential data are maintained.	The intent of this requirement is for procedures for surveillance systems that are collecting 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** be included for this measure. If vital records data are collected by the health department as part of the surveillance system, vital records could be included in the documentation for this measure. The requirement for this measure is one process or protocol that addresses all surveillance data activities the health department is involved in **or** a set of processes or protocols that together address all surveillance data activities. 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), or National Retail Data Monitor for Public Health Surveillance (NRDM), notifiable disease or other reporting systems, etc. 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. Other sites could include, for example, emergency management or a 9-1-1 call center. If the health department is engaged in chronic disease surveillance, the processes and protocols used for associated data activities would also be included. 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 (voice or fax), email addresses, or ability to submit a report electronically. Reports may be received by a contractor or by a call center (for example a poison control center), via regional or state agreements, or other arrangement. The health department defines from whom reports are received. 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. For required element c: While the process or protocol may not specify one specific method of data analysis, it will discuss how the health department is able to identify when the surveillance data deviates from expected trends. Knowing when acceptable thresholds have been exceeded will allow the health department to initiate additional investigation or mitigation	One department-wide process or protocol, or a set of processes or protocols	5 years

	steps. For required element d: The process or protocol will discuss how the health department is able to view data specific to sub-populations. 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 sub-populations. 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 each surveillance system. For required element f: The process or protocol will include methods by which surveillance data are maintained in a secure manner, which includes both physical data, such as, keeping a fax that receives data in a locked room, and electronic data, such as, data received via email having encryption protocols or firewalls. For required element g: The intent of this requirement 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 and after working hours. The frequency of testing may vary based on the system(s) used. 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 to demonstrate processes, protocols, roles and responsibilities, confidentiality protection and reporting.		

Measure 2.1.3 A: Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards. **Foundational Capability Measure**
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 of public health problems and environmental public health hazards for investigation and containment/mitigation. Health departments must have 24/7 access to these resources to facilitate prompt response to emerging health problems and hazards.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Policies and procedures outlining how the health department maintains 24/7 access to epidemiological and environmental resources for the detection, investigation, and containment/mitigation for both public health problems and environmental public health hazards.	Policies and 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 and procedures or environmental health investigation and containment procedures. Resources may be within the department, such as in-house environmentalists, sanitarians, and epidemiologists. 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.	1 comprehensive policy and procedure or a set of policies and procedures	5 years
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. If the type of lab testing performed by the laboratory is not included in the accreditation, certification or licensure, it must be listed on the coversheet. There must be at least one laboratory to which the health department has 24/7 access. 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. The coversheet may be used to indicate 24/7 access to laboratory support. Laboratory capacity could be, for example, 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, and others.	Accreditation documentation, certification, or licensure appropriate for all labs used by the health department for testing	5 years

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

Standard 2.2
Prepare for and respond to emergencies.

Measure 2.2.1 A: Maintain a public health emergency operations plan (EOP).
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess that the public health emergency operations plan describes the public health function in emergency response. Public health plays 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. The public health emergency operations plan or the public health annex to its jurisdiction's emergency response plan. The submitted plan or annexes must include: a. A description of the purpose of the plan. b. The description of incident command system, including designation of staff responsibilities.	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. Project Public Health Ready (PPHR) is a national model that could be used. Tribes may use guidelines that are most appropriate for their unique emergency management needs. The 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. For required element b: Staffing plans for command positions could include, for example, designation of the	1 plan	3 years

c. The identification of the needs of at-risk individuals, which must include those with access and functional needs. d. At least two examples of processes to meet the needs of at-risk individuals (identified in element c). e. The lead role agency(ies), as well as the responsibilities of the health department 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 f. The process of declaring a public health emergency. g. Activation of public health emergency operations, including levels of activation based on triggers/circumstances. h. The process for collaborative revision of the plan.	incident commander, finance/administration section chief, logistics section chief, operations section chief, planning section chief, and PIO. One individual may cover multiple ICS roles. For required element c: At-risk populations 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. Specific populations with vulnerabilities could include, for example, low-income, unhoused, or transient persons who do not have a permanent residence, those without a personal vehicle, persons with mobility impairments, those who need medical equipment in order to travel, or those with limited English proficiency. Individuals who do not trust the government or medical research due to a history of mistreatment could also be considered. Vulnerable populations 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, people with disabilities, etc.). For required element d: Processes to meet the needs (e.g., transportation needs, translation services, special outreach to counteract historical mistrust) of at-risk individuals 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 plan. For required element e: The coversheet 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, coroners, etc.). The coversheet table will also be used to indicate references (i.e., page numbers) to a description of the health department's responsibilities contained within the emergency operations plan, annex(es), or attachment(s). For required element f: The process to declare an emergency will include all steps needed to officially make an emergency declaration. The process could also include, for example, notification of staff,		

The EOP must cover the entire jurisdiction served by the health department or multiple EOPs must be provided.	decision-makers, key partners, etc.; the triggering of Mutual Aid Agreements/Memorandum of Understanding/contracts; etc. For required element g: The plan may describe thresholds for activation levels along with criteria for determining when a partial or full activation is necessary. Levels of activation are based on triggers and communication with the incident commander or unified command based on the jurisdiction's risk analysis. For required element h: The process for revisions will show how the plan is revised to incorporate feedback with other stakeholders. The revisions could be 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; or changes in the population or the risk factors in the jurisdiction (e.g., adding provisions to address fires if that risk increases or including outreach in additional languages or using community health workers, community health representatives, or others to better reach subpopulations).		

Measure 2.2.2 A: Implement administrative preparedness practices to ensure continuity of operations and rapid response.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess administrative preparedness plans in place to ensure continuity of operations, including expedited administrative processes. Administrative preparedness ensures fiscal, legal, and administrative practices are in place to ensure continuity of operations and remove barriers that can prevent the timely response during an emergency. Plans and processes that govern funding, procurement, contracting, and hiring require appropriate integration into all stages of emergency preparedness and response. A lack of administrative preparedness planning may result in delay of the acquisition of goods and services, the hiring or assignment of response personnel, the disposition of emergency funds, and legal determinations needed to implement protective health measures. (NACCHO 2021)

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
1. Continuity of operations plan, which must include: a. Identification of essential public health functions that must be sustained during a continuity event. b. Orders of succession. c. Identification of an alternate location for key health	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. For required element a: The health department will identify what public health functions or services must be	1 plan	5 years

department staff to report, if necessary, or the ability to work virtually.	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 resource or business functions, etc. For required element b: Orders of succession will include delegation of authority if leadership is unavailable to perform legally authorized roles and responsibilities. Identifying multiple individuals in the order of succession might allow for contingency planning, particularly in the context of a lengthy emergency. The orders could also include key positions, such as administrators, directors, and key managers, within the health department as well as defined roles and responsibilities. For required element c: Indicate alternate locations or if work can be performed virtually. The alternate facility(ies) could include considerations of alternate uses of existing facilities or the relocation of a limited number of key leaders and staff to a place where the potential disruption of the organization's ability to initiate and sustain operations is minimized. The plan could also address, for example, the conditions for the ability of staff to work remotely, such as protocols that describe provision of equipment and supplies, transfer of protected information, capability to hold virtual meetings, etc.		
2. The process for expedited administrative procedures used during a response to an event that differ from standard procedures for **all** of the following: a. Accepting, allocating, and spending funds. b. Managing/hiring workforce. c. Contracting/procuring or mutual aid.	The intent of this requirement is to ensure the health department has an established process to access funding, workforce, and other forms of assistance in an expedited manner during an emergency. Documentation of one specific instance when a health department expedited a contract, for example, would **not** meet the intent of the measure. The process could take several forms, including, for example: • A separate formal policy (if, for example, the health department included administrative or finance teams in preparedness planning to develop a stand-alone plan to expedite administrative procedures); • Part of the Continuity of Operations Plan (COOP); or • Less formal documentation such as a presentation, memo between other governmental entities, etc. to describe the health department's process for how it works with other governmental entities (e.g., the state health department, budget office, county council) to expedite administrative procedures. For required element a: The process could address, for example, expedited acceptance of emergency preparedness funding for immediate use, such as, establishing an emergency fund, or financial approval processes, etc. The state health department could, for example, consider processes for expediting the immediate use of funds among local or Tribal health departments (eliminating grant or applications or award restrictions). Examples of	1 process	5 years

	flexibility related to spending funds could include removing retroactive reimbursement mechanisms, removing or reducing spending restrictions, granting no-cost extensions or continuation awards, etc. For required element b: Examples could include expedited hiring or reassignment of staff or use of volunteers for surge (such as, the Medical Reserve Corps, CDC Foundation, or EIS/EpiAid deployments, etc), or implementing flexible practices for contract workers, hourly employees, etc. Methods could address building a volunteer database, reducing qualifications, or expediting background or credentialing verification processes. For required element c: The health department could expedite contracting or procurement of mutual aid, for example, related to procurement of supplies or transportation, or expedited purchase order practices, such as, relationships formed with supply companies to acquire medical supplies, including PPE or other equipment or facilities; Emergency Management Assistance Compact (EMAC); or mutual aid agreements or other agreements, such as those with local organizations or healthcare coalitions (HCCs), as applicable.		

Measure 2.2.4 A: Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency. **Foundational Capability Measure**
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. The goal is to ensure information is provided to the public about the actual and perceived public health risks, the possible solutions and actions that should be taken by the public, and related issues and concerns. Accurate and timely information—and efforts to dispel misinformation—can be critical in influencing behavior and ultimately affecting the population's health.

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
1. A risk communication plan that: a. Describes the process used to develop accurate and timely messages. b. Describes methods to communicate necessary information to the entire community, including at-risk subpopulations.	The risk communication plan outlines the activities for providing timely, effective communications. There is no required format for the plan; that is, it may be a part of a larger communications plan or part of an overall department emergency operations plan. A risk communication plan may be identified, for example, as an emergency communication plan, crisis communication policies, or other communication plan that includes risk communications. For Tribal health departments, documentation could reference an existing, approved Tribal	1 plan	5 years

c. Addresses misconceptions or misinformation. d. Describes the process to expedite approval of messages to the public during an emergency. e. Describes how information will be disseminated in the case of communication technology disruption. f. Describes the process for managing and responding to inquiries from the public during an emergency. g. Describes the process to coordinate the communications and development of messages among partners during an emergency. h. Contains a media contact list. i. Describes the procedure for keeping the media contact list current and accurate.	policy that identifies another Tribal employee or program (such as the Tribal emergency management planner) as being responsible for the risk communication plan and its implementation. Tribal health departments may provide a written MOU or MOA 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 required element a: To ensure information is accurate, the plan could, for example, include 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 being transparent about how data may be updated or change over time. To ensure information is 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 accordingly 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. For required element b: Methods of communications will vary based on the community. The entire community includes subpopulations and at-risk individuals, which may be identified, for example in a Communication, Maintaining Health, Independence, Services and Support, Transportation (CMIST) profile or Access and Functional Needs Plan. Subpopulations or at-risk individuals could include, for example, children, older adults, pregnant women, and individuals who may need additional response assistance, such as individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals who have chronic medical disorders, or individuals who have pharmacological dependency, as well as transient populations, such as unhoused individuals or migrant farm workers. Individuals who do not trust the government or medical research due to a history of mistreatment might also be considered. 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 media platforms to share accurate information from reputable sources, 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 findings and conclusions. For required element d: Expediting clearance methods 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 advisor 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. 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, etc. 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. 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 assess if communications are reaching intended target audiences. For required element h: The media contact list will include contact information. Restricted information may be redacted from the contact list. For required element i: The procedure could outline, for example, the frequency, staff member responsible, and elements of the media contact list reviewed and updated.		
2. Methods implemented to communicate with the public during	The intent of this requirement is to demonstrate multiple methods of communicating with the public during an emergency.	2 examples	5 years

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 can indicate that in the coversheet.	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, etc. 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, such as individuals who are deaf by using sign language interpreters. Other considerations might address cultural humility, which considers the way people view, experience and make choices about their health based on multiple factors, for example, religion, economic and educational factors, cultural values, beliefs, customs, and ways of living. Cultural humility considers the approach for tailoring communication messages in the context of underlying values, perceptions, and beliefs that could influence understanding and behavior based on the information shared. **DOCUMENTATION EXAMPLES:** Documentation could be press releases, television or radio interviews, mass emails, tweets, etc.		

Measure 2.2.5 A: Maintain and implement a process for urgent 24/7 communications with response partners.
Foundational Capability Measure

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 the appropriate public health response partners on a 24/7 basis. Accurate and timely information is necessary to ensure an appropriate and effective community-wide response. Partners need to know how to contact the health department to report a public health issue, but also need to have methods for receiving information from the health department about urgent public health issues.

Required Documentation	Guidance	Number of Examples	Dated Within
1. An emergency communication protocol, process, or system for contacting response partners 24/7 during a public health emergency, which must include: a. A list of response partners that	The intent of this requirement is that the health department has a process for contacting key response partners when an urgent public health issues arises and that the protocol can be used 24/7. This measure 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	1 comprehensive or set of protocols or processes	5 years

minimally includes health care providers, emergency management, emergency responders, and environmental health agencies. b. A description of how alerts are sent and received 24/7.	measures or information related to a public health problem, using multiple contact points in case of technology disruption. 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. 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. Examples could include health care providers, such as, hospitals, social service providers, emergency management, emergency responders (e.g., EMS, fire, police), pharmacies, mental health organizations, volunteer organizations, universities, the media, and neighboring health districts. Partners exist at the local, state, Tribal and federal levels. For required element b: If a series of screenshots are used to show the system, provide a description of how alerts are both sent and received on a 24/7 basis in the coversheet.		
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 normal business hours.	The intent of this requirement is that the health department has implemented the protocol provided in Required Documentation 1. Examples could be of either a test or an actual alert. **DOCUMENTATION EXAMPLES** Documentation could include, for example, screenshots, emails, reports or queries from the HAN, or other records of testing the protocol for contacting emergency response partners.	2 examples	5 years

Measure 2.2.6 A: Conduct exercises and use After Action Reports (AARs) to improve preparedness and response. **Foundational Capability Measure**
Purpose & Significance The purpose of this measure is to assess the 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 (HSEEP 2020). A process for After Action Reports provides 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 (HSEEP 2020). 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. (CDC, PHEP, ORR Interim Guidance, 2021)

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
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/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.	1 plan	5 years
2. Completed AARs, which include: a. Name of event/exercise. b. Overview of the event/exercise. c. Response partners involved. d. Notable strengths. 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.	The format of the AAR is not prescribed by PHAB but should minimally address the required elements listed in the Required Documentation column. The AARs may be from drills/exercises or real events. 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, and/or recovery), capabilities or objectives tested. 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. For required element d: 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. Strengths might relate to capabilities or objectives tested, or other findings. For required element e: Improvements could be, for example, in areas in which it was observed that a necessary procedure was not performed; where an activity was performed, but with notable problems; or where there were some subpopulations that were disproportionately affected in a negative way. Improvements could also expand on the identified strengths.	2 examples	5 years

	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 planning, etc. The health department and its partners determine the timetable for improvements.		
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; or adoption of new technology, standards, or best practices; or the process for exercises, training, administrative planning, etc. 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. Documentation could be, for example, documentation of a new training that was provided based on an improvement identified in the AAR or could be a revision that was incorporated into the EOP as identified by the AAR.	2 examples	5 years

Domain 3
Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.

Standard 3.1
Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

Measure 3.1.1 A: Maintain procedures to provide ongoing, non-emergency communication outside the health department.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's procedures for ongoing, non-emergency communications to the public. Procedures and protocols 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Procedures for ongoing, non-emergency communications. The procedures must: a. Include the process for ensuring information is accurate and timely. b. Describe the approach to tailoring communication to different audiences. c. Include the process for coordinating with community partners to promote the dissemination of unified public health messages. d. Describe the process to maintain a contact list of key stakeholders for communications. 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.	This measure relates to ongoing, non-emergency communications. Health departments should answer information requests in a timely and appropriate fashion and should obtain appropriate reviews and approvals of information they disseminate to ensure its accuracy. This includes responding to requests for information or materials that the health department distributes in its jurisdiction. There is no required format for the procedures. If a health department works with an office of public affairs, then documentation can come from that office to meet these requirements. For required element a: To ensure information is accurate, the procedure could, for example, include 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 being transparent about how data may be updated or change over time. To ensure information is timely, the procedure could, for example, include guidance about target timeframes for responding to information requests or flow charts for content review with target timeframes. For required element b: Audiences within the community include subpopulations and at-risk individuals. Tailoring communications so they are appropriate for different audiences could include considerations of, for example, language, health literacy, or cultural humility. Cultural humility considers the way people view, experience and make choices about their health based on multiple factors, for example, religion, economic and educational factors, cultural value, 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/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	1 department-wide procedure or set of procedures	5 years

	community's strengths, resources, and capabilities, rather than their problems and challenges) in their communications. 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 process 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 process might include working with partners to develop coordinated press releases, public service announcements (PSAs), or joint web or social media campaigns. Taking an asset-based approach will focus on the context of which community partners are involved and what resources are available in the community to appropriately tailor communication for different audiences. For required element d: The process 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., the state health department, neighboring 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 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; for example, the health director, deputy health director, or other staff assigned. The description should 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.		
2. Capacity to communicate with individuals who are: a. Non-English speaking, b. Deaf or hard of hearing, and	The intent 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;	1 example One example may reflect all required	2 years or current

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, MOA/MOU, etc.) that demonstrates access to such service.	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, presentations, etc. Examples of a specific communication (i.e., translated materials) would **not** be appropriate. 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 "Indian preference" 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.	elements or evidence could be provided in multiple examples to cover all three required elements.	agreement
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 (for example, urban radio stations; free community newspapers; migrant worker newspapers; immigrant, ethnically targeted, and non-English language newspapers or radio stations, etc.). **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

Standard 3.2
Use health communication strategies to support prevention and wellness.

Measure 3.2.2 A: Implement health communication strategies to encourage actions to promote health.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's communication strategies to the populations that it serves in order to prompt changes related to health risks, health behaviors, disease prevention, and wellness approaches. Culturally sensitive and linguistically appropriate information ensures that public health information is understandable. Information should be designed in consideration of reaching intended audiences. It 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Health communication strategies implemented to encourage actions to promote health, which includes: a. The final content that references an action that members of the public should take and describes why the action should be taken. b. A description of how the health department strived for cultural humility and considered linguistic appropriateness. c. How the information was shared or distributed. At least one example must be of an evidence-based or promising practice. 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.	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. For required element a: The final content will convey action members of the public should take with a description of the reason(s). For example, a youth tobacco campaign might recommend teenagers avoid vaping or other tobacco products because of the associated health risks or might link to a resource for parents about how to talk with their teenage children. For required element b: Health messages 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, consider health literacy, etc. 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. 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.	2 examples	5 years

	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 coversheet. The evidence-based or promising practice may relate to the topic of the message or strategy, or concepts in the way it was designed considering communication science, health promotion, or health education evidence-based or promising-practices. Documentation of input from the priority population could be, for example, a report of findings from a focus group, key informant interviews, or pull-aside testing; or minutes from a town meeting with the priority population or a meeting of an advisory group that includes members of the priority population. To demonstrate how that input was used in developing the communications strategy, the documentation could include a final document with highlights showing how the information from the priority audience was used or a description in the coversheet about how the dissemination strategy was developed based on that feedback. Input from the priority audience gathered during the development of educational materials/messages is intended to help shape the final content. Feedback after messages/materials are delivered (such as a program evaluation) would **not** be appropriate. 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. Required elements b and c may be indicated within the coversheet. Similarly, the coversheet may be used to provide evidence (e.g., citation or description) of the evidence-base or promising practice and description of input gathered from the priority population.		
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. These could be the same examples provided in Required Documentation 1 or they could be different examples. **DOCUMENTATION EXAMPLES** Documentation could include, for example, a fact sheet produced in coordination with other health departments/partners, a public service announcement developed in coordination with the governing entity, an email chain or memorandum with other health departments/partners, meeting minutes where messaging was discussed, or documented phone conversation discussing the message.	2 examples	5 years

Domain 4
Strengthen, support, and mobilize communities and partnerships to improve health.

Standard 4.1
Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

Measure 4.1.2 A: Participate actively in a community health coalition.
Foundational Capability Measure

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. 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Active participation in a current, ongoing community coalition that addresses multiple population health topics or in two coalitions that each address a single population health topic. Documentation must include: a. Purpose or intended goals of the coalition, including how they address disparities or inequities. b. Representatives from multiple sectors. c. Participation of community members. d. Year the coalition was established.	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, evidence should demonstrate the coalition is ongoing (i.e., has met or communicated in the past 2 years). 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 and/or community led engagement. The coalition may address a wide range of community health issues and may be the same group that developed the community health assessment and/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 worker/community, newborn screening, integrated chronic disease prevention, childhood obesity, etc. 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 at-risk 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.	2 examples of topic/population specific coalitions or one example of a coalition that works on 2 or more issues	2 years

e. Modes and frequency of interaction. 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 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, insurance status, etc.) 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 community health improvement planning efforts, strategic planning, data analysis, or community input. For required element b: Partners that represent various sectors of the community could include, for example, religious organization, real estate, local or state government (for example, elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.), businesses, industries, major employers in the community, chambers of commerce, civic groups, academia, or other health departments (local, state, Tribal, or military). For required element c: Community members could include, for example, individual residents that have expressed an interest, community members with lived experience, 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. For required element e: 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. **DOCUMENTATION EXAMPLES** Documentation could be a summary or report of the coalition(s), indicating ongoing activities; meeting minutes and agendas; progress reports; evaluations, etc. A roster of members will **not** be sufficient for this requirement, but it could be used to demonstrate elements b and c. If needed, the coversheet may be used to address required elements d and e.		

2. Strategies implemented through the work of the coalition(s) from Required Documentation 1.	The intent of this requirement is to document strategies that have been implemented. While strategies may include work completed as well as future plans, this requirement addresses the work that has been implemented. 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, policies that address social determinants of health, etc.	2 examples	5 years

Domain 5:
Create, champion, and implement policies, plans, and laws that impact health.

Standard 5.1
Serve as a primary and expert resource for establishing and maintaining health policies and laws.

Measure 5.1.2 A: Examine and contribute to improving policies and laws.
Foundational Capability Measure

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. To ensure that policies and laws that have public health implications are effective, health departments must be actively engaged in the review of proposed and existing policies. 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Findings from a review of current or proposed policies or laws shared with	The intent of this measure 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 findings with	2 examples	5 years

those who set or influence policy. The review must include: a. Consideration of evidence-based practices, promising practices, or practice-based evidence. b. Assessment of the impacts of policies/laws on health equity. c. Input gathered from stakeholders. For state health departments at least one stakeholder in element c must be a local or Tribal health department(s). Documentation includes both the findings from the review **and** how they were shared.	those who set or influence policies. Policies that only affect the health department's internal operations (e.g., HR policies) do **not** meet the intent of this measure. Documentation can address policies either in effect or proposed and can address policies at the local, Tribal, state, or federal level. Reviews could be of a policy that the health department enforces (e.g., laws related to indoor smoking or to the issuance of quarantine orders) or of a law that the health department has no legal authority to enforce, but that has implications for the health of the public in the jurisdiction of the health department. Policies or laws that others enforce but impact public health could include, for example, helmet use laws, school nutrition requirements, sale of tobacco products to minors, animal rabies vaccination laws, school requirements for proof of childhood vaccinations, or regulations to reduce carbon use or pollutants. 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 for policy makers. Those who set or influence policy could include, for example, governing entities; local, state, or federal legislative bodies; local boards of education, transportation, etc.; Tribal District Chairpersons; elected Tribal council committees; Tribal Legislative Counsel; Tribal Elected/Appointed officials; and Tribal Oversight Committees. 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 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 and findings. Due to the 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. For required element b: The assessment of the equity impacts of current or proposed laws might include an assessment of whether laws/policies have a disproportionate effect on one or more sub-populations 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 which have contributed towards higher health risks or poorer health outcomes among subpopulations. For required element c: Input could be gathered from community stakeholders or strategic partnerships including collaboration on the review with, for example, governmental agencies such as departments of transportation, aging, substance abuse/mental health, education, planning and development, etc.; healthcare-related organizations such as a hospital system; community groups or organizations such as 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 if the governing entity does not have the authority to set the law or policy under review is not under the control of that governing entity. For example, the health department could seek input from a local board of health about a state-level policy or it could seek input from an advisory board about a local policy. For state health departments, the intent of gathering input from health department(s) as a stakeholder is to ensure collaboration with Tribal or local health departments in reviewing policies or laws that may impact those Tribal or local health departments and the populations they serve. It is **not** necessary that the health department demonstrate input from the stakeholders about the entire analysis. The health department could, for example, gather stakeholder input on just one portion of the analysis. **DOCUMENTATION EXAMPLES** Documentation of the review (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 (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 findings with those who influence policy could be demonstrated by including email correspondence or other evidence of dissemination or record of public testimony.		

Standard 5.2
Develop and implement community health improvement strategies collaboratively.

Measure 5.2.2 A: Adopt a community health improvement plan.
Foundational Capability Measure

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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. A community health improvement plan, which includes all of the following: a. Health priorities, each of which must include: i. Measurable health objectives. ii. Improvement strategies or activities with timeframes. b. Policy change(s) needed to accomplish the identified health objectives and alleviate causes of health inequity. A minimum of 1 identified policy change is	A health improvement plan looks at population health across the jurisdiction. While some or many programs in the health department may have program-specific plans, they do not fulfill the purpose of the health improvement plan to address community priorities. For required element a: Improvement strategies may be evidence-based, practice-based, promising practices, or may be innovative to meet the needs of the population. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2030) should be referenced, as appropriate. Measurable objectives and time-framed strategies/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,	1 plan	5 years

required. c. Designation of organizations or individuals that have accepted responsibility for implementing strategies outlined in the health improvement plan. d. Identification of the assets or resources that will be used to address specific priority areas. e. Description of process used to track the status of the effort or results of the actions taken to implement CHIP strategies.	the activities may evolve as the community tests out solutions and makes adjustments. In those cases, the improvement strategies 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. For required element b: Policy changes could examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health. Policy changes considered could address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and climate change. Policies could include, for example, healthy vending policies or changes in zoning laws. For required element c: This may include assignments to staff or agreements between planning participants, stakeholders, other governmental agencies, or organizations. For this measure, agreements do **not** need to be formal, such as an MOA/MOU. 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, a strong business community, arts, etc. These assets will help the community address priority areas or implement strategies/activities. It is **not** necessary to include an asset/resource for each priority area. They may be included as part of the CHIP, as an addendum, or in a separate document. For required element e: The health department defines the process that will be used to track the progress on CHIP priorities/strategies. This may be included as part of the CHIP, as an addendum, or in a separate document.		

Measure 5.2.4 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes. **Foundational Capability Measure**
Purpose & Significance The purpose of this measure is to assess the health department's efforts throughout its policies, processes, and programs 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.

Required Documentation	Guidance	Number of Examples	Dated Within
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 may ensure that social, cultural, and linguistic characteristics of the various populations groups of the population it serves are incorporated into processes, programs, and interventions. 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), and individuals with disabilities.	1 policy or procedure that covers multiple program areas or 2 examples of policies/ procedures that are program specific	5 years
2. Strategy implemented to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities, in collaboration with stakeholders, partners, or the community. The documentation must define the stakeholders', partners', or community's role in the strategy.	The example may be related to the 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 policy implementation is **not** required. Public health strategies implemented may address social change, social customs, policy, 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. Collaboration with partners or stakeholders could include, for example, community or volunteer organizations, businesses and industries, academic institutions, or others including those who represent priority populations. Tribal health departments may decide which sub-populations within the Tribal population or community that their public health initiatives are developed to address health equity. 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, interagency, or the community; or other document that outline efforts, achievements, or implementation updates.	1 example	5 years

Domain 6:
Utilize legal and regulatory actions designed to improve and protect the public's health.

Standard 6.1
Promote compliance with public health laws.

Measure 6.1.4 A: Conduct enforcement actions.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's standardized approach to consistently implement enforcement actions. Enforcement actions require standard steps, criteria, and 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Procedures, protocols, or processes for enforcement program areas. At least one of the two examples must address infectious illness, if the health department has enforcement authority for at least one infectious illness.	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), and thus the codes alone are **not** sufficient. The protocols may reference the code but will include steps involved in how it is operationalized. Infectious illness examples could include, for example, enforcement of isolation and quarantine laws (e.g., infectious TB, Ebola, etc.), or infectious agents associated with foodborne illness originating from a regulated entity (e.g., salmonella, norovirus, campylobacter, etc.). Non-infectious areas could include, for example, Legionnaires, lead, cancer clusters, seat belt use, sale of tobacco products to minors, clean indoor air laws, etc.	2 examples	5 years
2. Enforcement procedures from Required Documentation 1 implemented.	The intent of this requirement is to show implementation of each of the two procedures, protocols, or processes 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.	2 examples	5 years

3. Information provided to regulated entities about their responsibilities related to public health laws. Documentation must include both the information provided **and** description of its distribution. One of the examples must demonstrate consideration of cultural humility, literacy, or other special communication considerations.	The information to regulated entities could be, for example, providing information or education to food service or pool operators, etc., on how to comply with safety requirements or regulations. Cultural, 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, etc. 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. **DOCUMENTATION EXAMPLES:** Documentation could be, for example, a set of FAQs on the health department's website, newsletters, training sessions, public meetings, documentation of technical assistance and information (provided through email, phone logs, etc.), pamphlets, posters, press releases or social media. The description of distribution may be included on the coversheet.	2 examples	5 years
4. Hearings, meetings, or other official communications with regulated entities regarding a compliance plan. Examples must include any resulting compliance plans.	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 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, or an enforcement letter sent to the regulated entity.	2 examples	5 years

Domain 7
Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.

Standard 7.2
Connect the population to services that support the whole person.

Measure 7.2.1 A: Collaborate with other sectors to improve access to social services.
Foundational Capability Measure

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 develop 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Multi-sector implementation of efforts to improve access to social services or to integrate social services and health care.	The intent of this measure is to describe 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 vulnerable populations 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, etc. The health department does **not** need to have convened or led the collaborative process, but it will have participated in the process to implement 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 recently executed MOU, etc. **DOCUMENTATION EXAMPLES** Documentation could include, for example, • A signed Memoranda of Understanding (MOU) between partners to list 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	2 examples	5 years

	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 vulnerable populations for the purposes of coordination of service programs (e.g., common intake form) and/or co-location (e.g., social services, WIC, immunizations, and lead testing) to optimize access. • 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.		

Domain 8
Build and support a diverse and skilled public health workforce.

Standard 8.1
Encourage the development and recruitment of a sufficient number of qualified public health workers.

Measure 8.1.2 A: Recruit a qualified and diverse health department workforce. **Foundational Capability Measure**
Purpose & Significance

The purpose of this measure is to assess the health department's recruitment 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 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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Efforts to recruit a qualified and diverse workforce. For health departments with fewer than 2 opportunities to recruit in the last 5 years, the health department is required to provide a detailed process/plan/procedure of how they would recruit a new employee in the event of a future vacancy.	The intent of this requirement is to demonstrate the department's recruitment efforts, not the success or failure to achieve the desired applicant pool. Recruitment efforts include both the qualifications listed within a job description as well as the methods used for recruitment. The qualifications could include competencies, knowledge, 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, 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. A workforce could be diverse as it relates to, for example, race/ethnicity, culture, language, age, gender, veterans, individuals with disabilities, individuals from a specific geographic area of the health department's jurisdiction, etc. Recruitment could include, for example, those with lived experiences, such as people in recovery (substance use program areas) or breastfeeding mothers (peer counselors, MCH), etc. Tribal health departments may use Indian Preference hiring policies. Including an EEO statement in a job posting does **not**, on its own, meet the intent of the requirement. **DOCUMENTATION EXAMPLES** Documentation could include, for example, job postings in media sources that reach specific populations, competency-based job descriptions in newsletters targeting 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 possess to qualify for the position.	2 examples	5 years

Standard 8.2
Build a competent public health workforce and leadership that practices cultural humility.

Measure 8.2.1 A: Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.
Foundational Capability Measure

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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. A health department-specific workforce development plan that includes: a. A description of the current capacity of the health department both as a whole and within each of its sub-units. b. An organization-wide assessment of current staff capabilities against an adopted set of core competencies. c. A description of gaps in capacity or capability as identified through the findings from a and b above. The description must address the following areas: i. Technology advances. ii. Other gaps identified by a and b above. d. Findings from an equity assessment that considers staff competence in the	The workforce development plan articulates specific objectives and strategies the health department plans to undertake to achieve its desired future workforce, based on considerations of the health department's current gaps in capacity and capabilities, particularly within areas in which the field is advancing. For required element a: The health department could use various tools or assessments to understand the current collective capacity of the department as a whole and its sub-units. Methods could include, for example, calculating health department current and projected needed staffing capacity compared to population size; benchmarking to other health departments performing similar functions within similarly sized jurisdictions; 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. For required element b: 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, and 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. For required element c: The intent of this requirement is that the health department consider gaps in the existing capacity or capability of its workforce identified as part of elements a and b. For example, informatics expertise or use of new or more advanced technologies could provide opportunities for efficient work in a digital age. Other areas identified by the health department	1 plan	5 years

areas of cultural humility, diversity, or inclusion. e. Plans to address at a minimum two of the gaps in capacity or capabilities (element c) or the findings of the equity assessment (element d); for each gap, documentation must include: i. Measurable objectives. ii. Improvement strategies or activities with timeframes.	could include, for example, 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, etc. For required element d: The intent is that the health department consider the workforce's competence related to health 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, 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, immigrant communities, etc.). 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. For required element e: Plans will relate to the gaps in capacity or capabilities described in element c **or** to the findings from the equity assessment in element d. The health department can select which gaps it will prioritize to address. Objectives will be written in measurable form with corresponding activities that have timeframes for completion. For example, the health department 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. Gaps in capabilities could be addressed, for example, by planning training for environmental health staff about new enforcement requirements. The workforce development objectives could be tied to the health department's strategic plan.		
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, element c) or the equity assessment (Required Documentation 1,	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, 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 which correspond to identified gaps in capacity or capability based on the assessment within the workforce development plan. Learning opportunities could help the health	1 list	2 years

element d). At least one of the learning/educational opportunities will include training on equity, diversity, inclusion, or cultural humility.	department to address capacity gaps by allowing staff to be cross trained to allow existing staff 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), Public Health Foundation's TRAIN Learning Network, etc.		

Measure 8.2.2 A: Provide professional and career development opportunities for all staff.
Foundational Capability Measure

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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Individualized professional development plans for non-managerial staff including evidence or 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.	2 examples	2 years

	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; health 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.		
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/manager or staff who are not currently in a leadership role, which may 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, and 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/management, or related meetings and conferences.	2 examples	2 years

Domain 9
Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.

Standard 9.1
Build and foster a culture of quality in public health organizations and activities.

Measure 9.1.1 A: Establish a performance management system.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the department-wide performance management system. A performance management system encompasses all aspects of establishing and evaluating the achievement of goals, objectives, and improvements or actions across programs, policies, and processes. The design of the performance management system should consider community health needs and priorities, including health inequities or disparities, to demonstrate the work of the health department and public health system to improve health outcomes. An adopted performance management system fosters transparency by communicating across the department how the department will (1) ensure that goals are being met consistently in an effective and efficient manner and (2) identify the need to improve organizational results.

Required Documentation	Guidance	Number of Examples	Dated Within
1. A department-wide performance management system, which includes: a. The performance management system showing goals and the related objectives with time-framed targets. b. A functional description of how the performance management system operates, including the process for how staff will: i. Enter data in the performance management system. ii. Analyze data. iii. Communicate results on a regular reporting cycle.	The intent of this requirement is to demonstrate how the health department uses one system organization-wide to track 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. Performance could be managed in, for example, a software program purchased or developed by the health department for this purpose, 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; etc.). However, if that is the case, specific application to the public health programs or initiatives will be described in the required documentation.	1 performance management system	5 years

iv. Use data to guide decision-making. v. Use data to facilitate continuous quality improvement. c. Linkages between the performance management system and strategic plan.	Within a performance management system, data can be qualitative or quantitative in nature and can be collected from secondary sources to which the health department has access or can be primary data collected by the health department. 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 they are meeting their performance goals established through state program requirements. • Surveillance systems to determine whether they are meeting their performance goals associated with timeliness of communicable disease reporting or case follow-up. • Internal data systems for collecting progress updates from staff responsible for strategic plan objectives. For required element a: Goals are established by the health department. They are intended to serve as the anticipated result or outcome the health department desires to achieve. Goals have associated performance objectives (also may be termed as measures or indicators) by which the health department will assess the extent to which programs, policies, and processes are achieving intended results/targets. Objectives will be written clearly in measurable and time-bound form, and could be written, for example, in SMART or SMARTIE form (Specific, Measurable, Attainable, Relevant, and Time-bound and/or through an Inclusive and Equitable lens). 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, 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). Documentation may demonstrate a sub-set of the performance manage system through screenshot(s) or other documentation. The documentation does **not** need to		

	show every goal and objective, but will provide a view of the breadth of the goals included in the performance management system. For required element b: The functional description of the performance management system could be a description, policy, or plan (separate plan or integrated with the QI 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 will 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. Analyze data. This could include, for example, how data are analyzed 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, annually, etc.) 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. Analysis of performance management data could lead to the identification of a quality improvement project, for example. For required element c: Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities, or the mission or vision of the department. 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 coversheet may be used to clarify and describe linkages.		

Measure 9.1.5 A: Implement quality improvement projects.
Foundational Capability Measure

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 can increase the effectiveness and efficiency of existing processes.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Completion of quality improvement (QI) projects that demonstrate the following: a. How the opportunity for improvement was identified. b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement. c. Use of a QI method. d. Use of QI tools to better understand or make decisions about: i. The current process, effort, or gap. ii. Root cause(s). iii. Possible solutions. iv. Prioritization/selection of solutions for implementation. e. A description of the outcomes of the QI project, including progress toward the measurable objective(s) established in required element a. The description must include data used to	The intent of this requirement is for QI projects that have gone through at least one full project cycle. Projects that are still in-process at the time of documentation submission would **not** meet measure requirements. Examples will focus on improvement of existing projects, programs, or efforts rather than on use of QI tools to plan new projects, programs, or initiatives. Programmatic areas could include projects focused on improving existing processes related to, for example, engagement of partners or community members in the community health assessment process; reducing youth vaping rates in high-risk communities; revising intake processes for community members using health department services; or increasing community participation in a walking challenge intended to promote physical activity. Program examples could also focus on exploring root causes or barriers to streamline or improve existing processes that could impact health equity. This could include QI projects aimed to, for example, increase use of farmers markets in identified food desert areas, improve transportation systems, or streamline existing coordination of care processes using Community Health Workers or Community Health Representatives. Administrative areas could include, for example, projects focused on administrative elements or activities related to individual programs or could relate to administrative tasks that affect the entire health department. Administrative areas could include, for example, improving timesheet approval processes, improving recruitment processes to increase the diversity of the hiring pool, new employee onboarding processes, or the contracts management process (for the health department as a whole or for the environmental health program, for example). For required element a: Identification of problems or opportunities for improvement could occur 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.	2 examples	5 years

determine whether the project's objective(s) was met and identify next steps resulting from the project. One example must be from a program area and the other must be from an administrative area.	For required element b: Those engaged in the project will establish 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. 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, or other recognized QI methodologies. 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. To have the greatest opportunity for improvement, the health department will uncover root causes (ii) and factors contributing to the issue under review. QI tools could include, for example, affinity diagrams, brainstorming, flow charting, fishbone diagrams, check sheets, control charts, force field analyses, Gantt charts, interrelationship diagrams, logic models, pareto charts, and swim lane maps. There are generally many possible solutions (iii) to a given problem. The health department will identify several possible solutions have options when determining which solution(s) to test through the improvement effort. QI tools could include, for example, brainstorming and SWOT Analysis. With more than one option, 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. 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 include, for example, a plan for institutionalizing the improvement as the new established process, or could determine they need to go back to an earlier step in their QI process and initiate another improvement cycle where they can 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. **DOCUMENTATION EXAMPLES** 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.		

Standard 9.2
Use and contribute to developing research, evidence, practice-based insights, and other forms of information for decision making.

Measure 9.2.1 A: Identify and use applicable research and practice-based information when implementing or revising processes, programs, or interventions.
Foundational Capability Measure

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, and interventions, as appropriate. The use of these types of practices helps assure that health department resources are being allocated and applied as effectively as possible.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Incorporation of research or practice-based information in the development of a new public health process, program, or	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	2 examples	5 years

intervention or revision to an existing program, process, or intervention. The examples must address: a. The research or practice-based information source. b. A new or revised process, program, or intervention that reflects the information in required element a. 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 program, process, 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.	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 the Indian Health Services (IHS) or other Tribal-specific research sources. A web link to the research or practice-based information may be included on the coversheet if at least a summary or abstract of the information is publicly available. If it is not publicly available, a copy of the article, etc., or a screenshot that shows the abstract or summary will be provided. 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 program, process, 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 coversheet or description could indicate whether the program, process, or intervention is new or revised/updated based on the identification of research or practice-based evidence. 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 could be adapted to fit the special considerations of that target 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. Due to the 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.

Standard 10.1
Employ strategic planning skills.

Measure 10.1.2 A: Adopt a department-wide strategic plan.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's adoption of a department 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 through processes linked within the performance management system. The strategic plan outlines the health department's contributions towards improving health outcomes outlined in the community health improvement plan.

Required Documentation	Guidance	Number of Examples	Dated Within
1. A department-wide strategic plan, which must include: a. The health department's mission, vision, and guiding principles/values for the health department. b. Strategic priorities. c. Objectives with measurable and time-framed targets. d. Strategies/actions to address objectives. e. A description of how the strategic plan's implementation is monitored, including progress towards achieving objectives, and strategies/actions. f. Linkage with the community health improvement plan.	The intent of this measure 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 goals in the plan could be for a longer time period than five years, but the plan will have been produced or revised within the last five years. For required element b: Strategic priorities outline what the health department plans to achieve at a high level in order to accomplish its vision (or the future state of the health department). Strategic priorities could be called by a different name (e.g., strategic goals, etc.). For required element c: Measurable and time-framed objectives with 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 measure. Objectives will be measurable	1 strategic plan	5 years

g. Linkage with performance management. 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 a section that addresses the health department and includes the required elements of the plan specific to the health department. If the plan of the super health agency or umbrella agency does not include the required elements for the health department, then the health department must document that it has conducted an internal health department planning process and adopted a health department specific strategic plan or supplemented the plan to address required elements above.	and time-bound, and could be written, for example, in SMART or SMARTIE form (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive and Equitable). 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 measure. For required element e: The intent of this requirement is to describe how the health department monitors progress toward implementing the strategic plan, including strategic priorities, objectives, and strategies/actions, as identified in required elements b-d. Implementation of the strategic plan could be monitored, for example, through the performance management system, through regularly scheduled meetings or progress reports, etc. For required element f: Linkage could include, for example, strategic priorities aligned with priorities identified in the 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 its capacity to conduct surveillance related to maternal and child health in order to build the department's ability to support the community partnership in this area. For required element g: Linkage with performance management could include, for example, strategic plan priorities or activities which 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/performance management methods to meeting a priority related to expanding the health department's communications reach within the community). For required elements f and g, the strategic plan does **not** need to link to all elements of the community health improvement plan or performance management, but it will show where linkages are appropriate for effective planning and implementation. The coversheet could be used to clarify and describe linkages (required elements f-g).		

Standard 10.2
Manage financial, information management, and human resources effectively.

Measure 10.2.2 A: Maintain a human resource function.
Foundational Capability Measure

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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. A human resource manual or set of policies and procedures that address each of the following: a. Personnel recruitment, selection, and appointment. b. Equal opportunity employment. c. Confidentiality of employee information and personnel records. d. Salary structure. e. Benefits package. f. Performance evaluation process based on either job/position descriptions or annual objectives. 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.	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 (e.g., 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. If the policies and procedures are not maintained by the health department, the coversheet could be used to provide a description of the human resource system. 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)]. For required element c: The requirement is referring to employee records (e.g., policy on confidentiality of employee records); it is **not** referring to expectations regarding HIPAA or protecting client health information. For required element f: Performance evaluation processes could include, for example, annual reviews, 360 evaluations, etc. The intent of this requirement is that the health department demonstrate reviews are conducted based on merit and evaluate employee performance according to position expectations/requirements.	1 set of HR policies	5 years

	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, and processes for how they are resolved.		

Measure 10.2.3 A: Support programs and operations through an information management infrastructure. **Foundational Capability Measure**
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.

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
1. A process for how staff request updates, enhancements, or replacement of information management systems used by the health department, **and** how those requests are reviewed.	The intent of this requirement is to demonstrate how the information management infrastructure supports programs and operations. It is possible that there are multiple processes used in the health department (e.g., one process by which employees request updates to hardware/software to ensure they can perform their job functions and a separate process for how the health department considers 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. 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. 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 community health improvement plan. **DOCUMENTATION EXAMPLES:** Documentation could include, for example, a standard operating procedure, request form template, flow chart, etc.	1 process	5 years

Measure 10.2.4 A: Protect information and data systems through security and confidentiality policies. **Foundational Capability Measure**
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 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, states, or local laws; diminished credibility or trust among community members; and vulnerabilities in maintaining operations and provision of services.

Required Documentation	Guidance	Number of Examples	Dated Within
1. An adopted, department-wide information security policy that includes the following: a. A description of the requirements for password complexity **and** lifespan. b. A process for ensuring physical security of information **and** network security. 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. ii. A process for user access management for electronic data and data systems. iii. A process for maintaining confidentiality of paper versions of those data.	The health department should 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 policy. The intent of this measure is **not** confidentiality of employee records (covered in HR functions measure). Health departments could use government-wide (i.e., state, city, or county) or super-health agency or umbrella agency policies and procedures. Tribal policies could be government-wide, or Tribal-wide. These policies and procedures could demonstrate conformity with the measure if they apply to the health department. 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. For required element b: Physical security of information requires procedures 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; protections for environmental hazards (e.g., climate-controlled secure server rooms or use of surge protectors); etc. For required element c: The process for privacy protection could be part of a separate policy. Confidentiality policies may 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	1 policy or set of policies	5 years

	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 of those data and systems. As appropriate, the health department could classify an entire system (e.g., a surveillance system) or it could classify certain fields within the system. Classifications could include, for example: • Sensitive data are data that are not meant to be made public. Sensitive data systems could include, for example, immunization data registries, reportable disease records, or vital records. • Mission-critical data are any data or systems that, if compromised or unavailable to users for long periods of time, would prevent the health department from being able to conduct its business functions. Mission-critical data or systems could include, for example, systems for collecting payment for environmental health licenses or permits. 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 the 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. 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.		
2. Evidence that **all** staff have participated in information security training, which at a minimum includes: a. Password complexity. b. Phishing. Documentation must include evidence of training content **and** staff participation in the training. State health departments in a centralized system must demonstrate that training was also provided to state health	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, if the health department staff were included in the training. Required element b: 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	1 example	2 years

department employees serving local jurisdictions.	(e.g., personally identifiable information, banking and credit card details, and passwords). It is important that health department staff are trained on how to identify phishing to avoid falling victim to this practice. **DOCUMENTATION EXAMPLES:** Documentation could include, for example, a copy of the training materials along with certificates, records of staff completing training, sign-in sheets, or a log. A signed acknowledgment of reviewing a policy alone would **not** meet the intent of training for this requirement.		
3. Acknowledgement that **all** employees received confidential data handling policies, which includes: a. A confidentiality form or agreement that is signed by employees. b. A record or log demonstrating that employees have signed the confidentiality form or agreement.	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. **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 a software program or system that shows signed forms from all staff.	1 form and 1 example of a completed tracking form or log	5 years

Measure 10.2.6 A: Oversee grants and contracts.
Foundational Capability Measure

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, processes, 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.

Required Documentation	Guidance	Number of Examples	Dated Within
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 measure 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 they distributed them appropriately in the community.	2 examples	5 years

	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.		
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; 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 and 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 EXAMPLES** 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). 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.	All, as appropriate	5 years
3. Signed contracts or MOU/MOAs or other written agreements with organizations outside the health department that outline how those other organizations will provide services, processes, programs, or interventions **on behalf of** the health department. The examples must be from two different	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. **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.	2 examples	5 years

areas. Each example must feature a written agreement with a different organization whereby the other organization is agreeing to provide a service, process, program or intervention on behalf of the health department. Only one example can be with another health department.	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 measure. 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 Regional Epidemiologic Centers.		
4. Improvements 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 improvements 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; or issuing or receiving resolution of corrective action reports to the contractor if the 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, conducting 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.	1 example	5 years

Measure 10.2.7 A: Manage financial systems.
Foundational Capability Measure

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.

Required Documentation	Guidance	Number of Examples	Dated Within
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.	2 examples	2 years
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.	2 examples	5 years (two most recent audits)
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 in the coversheet.	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, defining clear roles and responsibilities, etc.	1 example	3 years

Standard 10.3
Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision-making, and governance.

Measure 10.3.2 A: Communicate with the governing entity about its responsibilities, the responsibilities of the health department, and health status of the community.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to inform the governing entity of its responsibilities, the responsibilities of the health department, and health status of the community. Governing entities significantly influence the direction of health departments through policy making and other activities. Many governing entities have key roles in resource allocation, policy making, legal authority, collaboration, and quality improvement activities. To be an effective advocate for public health and for the agency, the governing entity will be aware of its responsibilities and duties, the health department's roles and responsibilities, and the health status of the community.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Orientation of new members of the governing entity(ies). New member orientation must include: a. The responsibilities of the health department, including major programs **and** public health authorities. b. The responsibilities of the governing entity. c. The health status of the community **and** priority issues. If the health department has multiple governing entities, it must provide examples for each governing entity. If no new governing entity members have been appointed/elected in the last 5 years, the documentation must show an	The intent of this requirement is to provide documentation that demonstrates the process that was used to orient new governing entity members, which includes the responsibilities of the health department and governing entity. The health department could have multiple governing entities (e.g., city council, county commissioners) or entities which serve in an advisory role. The health department will show examples of orienting each of these entities. For required element a: The description of the responsibilities could include, for example, major program areas and population health initiatives (e.g., maternal and child health, chronic disease), enforcement authority, etc. For required element b: The responsibilities will relate to the authorities for the governing entity. For example, some entities have the authority to issue a public health order, while others serve in an advisory capacity. For required element c: The orientation could include, for example, sharing the CHA findings and priorities identified in the CHIP.	1 example per governing entity	5 years

implementation of the orientation process with the full governing entity(ies) as a refresher.	**DOCUMENTATION EXAMPLES** Documentation could include, for example, meeting minutes, PowerPoint presentation, or orientation materials.		

Measure 10.3.4 A: Access and use legal services in planning, implementing, and enforcing public health initiatives. **Foundational Capability Measure**
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).

Required Documentation	**Guidance**	**Number of Examples**	**Dated Within**
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 and/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, MOUs/MAAs, etc.) 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.	1 example	5 years