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

- Some of the content has shifted location to align with the 10 Essential Public Health Services—for example, the strategic plan is now in Domain 10.
- Version 2022 for initial accreditation requires approximately 120 fewer documents than version 1.5.
- 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.
- Version 2022 designates which measures align with the Foundational Capabilities. (See https://phnci.org/national-frameworks/fphs for more information on these components of public health infrastructure.)
- Considerations related to equity are included in every domain.
- 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. While these requirements are the most changed from Version 1.5, we think the new requirements will be familiar to many health departments.
- Several items that used to be required as part of Version 1.5 Standards & Measures will be collected as part of the application instead (e.g., ADA compliance documents, organizational chart, laws/regulations).

For more information on Version 2022, including videos and an FAQ, visit: https://phaboard.org/version-2022/.

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
</table>
| 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:  
  i. At least 2 organizations representing | 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 but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders. | 1 community health assessment | 5 years |
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.

e. A description of health challenges experienced by the population served by the health department,

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 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:
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.

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 healthcare 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.

<table>
<thead>
<tr>
<th>Measure 1.1.2 A: Ensure the community health assessment is available and accessible to agencies, organizations, and the general public.</th>
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<tbody>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
</tr>
<tr>
<td>The purpose of this measure is to assess the health department’s efforts to share the community health assessment with other agencies and organizations and to make the assessment results available to the general public. The community health assessment is a resource for all members of the public health system and the population at-large. It serves as a foundation for collaboration, priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets and resources to improve population health. Other governmental units and not-for-profits will use the community health assessment in their planning, partnership and program development, and development of funding applications.</td>
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<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Key findings <strong>and</strong> the full community health assessment actively shared to inform others about the community health assessment. One example must show actively informing organizations including those that are <strong>not</strong> members of the community health assessment partnership. The other example must show actively informing the public.</td>
<td>The intent of this requirement is to demonstrate active methods of informing the public and additional partners, stakeholders, agencies, associations, or organizations about the key findings <strong>and</strong> availability of the community health assessment, rather than passive methods of sharing, like posting it on a website; thus, a link to/screenshot of a website alone would <strong>not</strong> be sufficient. Key findings could include, for example, a summary of key points posted to a website, executive summary portion of the full assessment, letter summarizing findings, or data visualization tool. Tribal health departments should ensure that the community health assessment is available to the broadest community possible in the context of the Tribal setting. In respecting the sovereignty of the Tribe to make the most appropriate decision about sharing reports from its data, PHAB does not require that Tribal health departments post their community health assessment on their website. However, documentation must be submitted that indicates with whom the community health assessment was shared and how it was shared. <strong>DOCUMENTATION EXAMPLES</strong> Documentation of notification of organizations and stakeholders could be, for example, copies of emails to partners and stakeholders providing information of how to access the assessment which includes key findings; or meeting minutes showing discussion of where and how partners and stakeholders can access the assessment as well as key findings. Documentation of notification to the public could be, for example, evidence of hard-copy distribution of the community health assessment’s key findings (with information on how to access the full report) to libraries or a press release including instructions for accessing the</td>
<td>2 examples</td>
<td>5 years</td>
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</table>
community health assessment and its key findings. Links to the CHA and key findings could be, for example, published in newspapers, included in the department’s newsletter, included in a public service announcement, or included in a social media post.

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## 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

<table>
<thead>
<tr>
<th>GUIDANCE</th>
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<tbody>
<tr>
<td>Surveillance data, program evaluation, and customer satisfaction do <strong>not</strong> meet the intent of this measure.</td>
</tr>
<tr>
<td>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.</td>
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<tr>
<td>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).</td>
</tr>
<tr>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
</tr>
<tr>
<td>Documentation could be, for example, copies of data collection instruments used <strong>and</strong> 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.</td>
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</table>

### Data Must Provide Information About

- the health status of the population or the factors contributing to the health status.

### Required Documentation

<table>
<thead>
<tr>
<th>GUIDANCE</th>
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</thead>
<tbody>
<tr>
<td>Program evaluation and customer satisfaction data do <strong>not</strong> meet the intent of this measure.</td>
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### Number of Examples | Dated Within |
<table>
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<tbody>
<tr>
<td>2 examples</td>
<td>5 years</td>
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<tr>
<td>2 examples</td>
<td>5 years</td>
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</tbody>
</table>
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.

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.

**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.

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<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>1. Participation in data sharing with other entities, by either: a. Providing data to another entity; OR b. Receiving data from another entity; OR c. Providing a data use agreement with another entity. The data being shared must include record-level data. For this measure, the examples cannot demonstrate data sharing with a local health department’s</td>
<td>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 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</td>
<td>2 examples</td>
<td>2 years</td>
</tr>
</tbody>
</table>
respective state health department. | 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.

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**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**

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</table>
| 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**

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 examples | 2 examples | 5 years |
| 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. |

2 examples | 5 years |

2. Tribal and local health departments asked about what support or technical assistance is needed to enable their participation in statewide data | **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.

2 examples | 5 years |
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.

<table>
<thead>
<tr>
<th>3. Support or technical assistance provided to Tribal and local health departments to be responsive to their needs concerning participation in statewide data systems.</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The state health department <strong>cannot</strong> 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.</td>
</tr>
<tr>
<td>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, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful.</td>
</tr>
<tr>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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<tr>
<th>4. A data use process that includes: a. A description of how the health department makes data and</th>
<th>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</th>
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<tbody>
<tr>
<td>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</td>
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<tr>
<td>1 policy or procedure</td>
<td>5 years</td>
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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.

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.

<table>
<thead>
<tr>
<th>Standard 1.3</th>
<th>Analyze public health data and share and use the results to improve population health.</th>
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</thead>
<tbody>
<tr>
<td>Measure 1.3.1 A: Analyze data and draw public health conclusions.</td>
<td><strong>Foundational Capability Measure</strong></td>
</tr>
<tr>
<td>Purpose &amp; Significance</td>
<td>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.</td>
</tr>
<tr>
<td>Required Documentation</td>
<td>Guidance</td>
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<tr>
<td>1. Data analyzed, which includes:</td>
<td>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,</td>
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</tbody>
</table>
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., YRBS), 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:
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.
## Purpose & Significance
The purpose of this measure is to assess the health department’s ability to provide findings that are accessible to the intended audiences. It also assesses the health department’s ability to discuss public health findings with various audiences. Public data analyses and findings, as they pertain to the jurisdiction, should be shared for the purposes of translating data into action. Community members, partners, governing entities, governmental units, and others are more able to effect change if they are aware of the status of the health of the community. Sharing findings can facilitate community action for improvements to public health issues and their contributing factors.

### Required Documentation

<table>
<thead>
<tr>
<th>Number of Examples</th>
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<tr>
<td>2 examples</td>
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<tr>
<th>Required Documentation</th>
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<tr>
<td>1. Materials developed and distributed that present key findings drawn from data in a way that is understandable to the public. The source(s) of the data used must be referenced in the materials. Materials must include at least some key findings about data specific to the population or a subset of the jurisdiction’s population served by the health department.</td>
<td>The examples for this required documentation could relate to the examples provided in Measure 1.3.1 or could present different data findings. The intent of this requirement is that data analysis has been translated so that the information included in the materials developed is easily understood by the public. A long, technical report would not meet the intent of this requirement. While not a requirement of this measure, health departments are encouraged to incorporate data from multiple sources, datasets, or different data topics and/or use a combination of primary and secondary data to support conclusions when developing materials. Using multiple, credible sources is one way to help preserve the public’s trust in public health findings and conclusions. While the data analysis and findings may be performed by others, the intent of this requirement is that the materials will include data specific to the jurisdiction or a subset of the jurisdiction’s population served by the health department. That is, the use of only state level data or data that address another jurisdiction will not be accepted from a local or Tribal health department; the use of only national level data or data that address another jurisdiction will not be accepted from a state health department. For example, a local health department could use reports produced by the state, an academic institution, or other organizations if jurisdictional data and findings are incorporated into the material. Distribution of the material could be targeted to a variety of audiences, including but not limited to public health organizations, health care providers, employers, community service groups, local schools, labor unions, other public health stakeholders, partners, the general public, etc. A range of distribution methods could be used including, for example, mailing lists, email lists, presentations, workshops, social media postings, etc. Posting materials to the health department’s website, would not demonstrate distribution unless the posting was accompanied by sharing the website link with others. <strong>DOCUMENTATION EXAMPLES</strong> Examples of materials that present public health data findings, could include, for</td>
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**DOCUMENTATION EXAMPLES**
Examples of materials that present public health data findings, could include, for
example, an infographic about health behaviors; dynamic webpage with disease clusters or trend information; environmental public health hazards brief report (e.g., lead or water); or data visualization on health indicators (e.g., infant mortality rate), etc.

Documentation of distribution could include, for example, a presentation discussing sharing of data analysis findings, an email to partners informing them of the availability of findings on the health department’s website, or a social media post informing followers how to access a data visualization platform, etc. If appropriate, the method of distribution could be indicated in the coversheet (for example, if the health department distributed a one-page summary of findings to individuals as they enrolled in WIC benefits or at a health fair.)

2. Key findings based on data analysis reviewed and discussed with others.

One example must demonstrate the review and discussion with the health department’s governing entity.

The data analysis used to develop key findings must include at least some data specific to the population served by the health department or a subset of the jurisdiction’s population.

The intent of this required documentation is to document data analysis and findings are reviewed and discussed to facilitate their use by others.

Examples of public health findings could include, for example, findings about health behaviors; disease clusters or trends (e.g., cancer or STIs); public health laboratory reports; environmental public health hazards reports (e.g., lead or water); or health indicators (e.g., infant mortality rate).

Review and discussions could occur with members of the governing entity; with community groups; with other health or social service organizations; or with bodies of other elected officials.

The examples of review and discussion for this required documentation could relate to the examples provided in Measure 1.3.1, Measure 1.3.2 Required Documentation 1, or could demonstrate review and discussion of different data analysis findings.

**DOCUMENTATION EXAMPLES**

Documentation could be, for example, minutes or documentation of meetings to show the presentation, review, and discussion of data analysis findings.

Measure 1.3.3 A: Use data to recommend and inform public health policy, processes, programs, and/or interventions.

**Purpose & Significance**

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

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<th>Required Documentation</th>
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<tbody>
<tr>
<td>1. Public health data analysis used to inform the development, revision, or expansion of policies, processes,</td>
<td>The intent of this required documentation is to demonstrate how data analysis has been used. Data alone are <strong>not</strong> sufficient evidence for this required documentation. Policies, processes, programs, or interventions that affect health department employees only do</td>
<td>2 examples</td>
<td>5 years</td>
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programs, or interventions that are designed to impact the population.

Documentation must identify both the data analysis findings used and the resulting policy, process, program, or intervention.

**not** meet the intent of the measure.

**DOCUMENTATION EXAMPLES**

Documentation could be, for example, submitted grant applications or program revisions or expansions. For example, an expansion of an existing diabetes prevention education program based on an increase in diabetes rate; a revised or new policy and procedure for tobacco free zones based on vaping data; a new program to build community resilience based on data about the impacts of climate change; or revisions to an existing surveillance process or procedure that adds a new reportable condition to those tracked by the health department based on emerging data.

Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data was used to inform policy, processes, programs and/or interventions.

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**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)

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<tr>
<td>1. Process(es) or protocol(s) for collection and analysis of public health surveillance data.</td>
<td>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</td>
<td>One department-wide</td>
<td>5 years</td>
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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.

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 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 2.1.2 A: Communication with surveillance sites.

Purpose & Significance
The purpose of this measure is to assess the health department’s regular contact with sites responsible for reporting surveillance data to the health department. The health department ensures that surveillance data reporting sites are providing timely, accurate, and comprehensive data by communicating with and training them about their public health surveillance responsibilities.

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<tr>
<td>1. The process to maintain updated contact information for sites that provide surveillance data to the health department and evidence of a surveillance site list.</td>
<td>The intent of this requirement is to ensure the health department has current contact information for sites reporting surveillance data to allow for an effective and efficient flow of information, including information about their responsibilities for reporting. Regularly updated and verified list(s) supports surveillance efforts, contributes to epidemiological investigations and encourages ongoing engagement. Examples of surveillance sites included in the list could include, for example, health care providers, schools, laboratories,</td>
<td>1 process and 1 partial or full list</td>
<td>2 years</td>
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<tr>
<td>2.</td>
<td>Training provided to surveillance sites about the following:</td>
<td>2 examples</td>
<td>2 years</td>
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</tr>
<tr>
<td>a.</td>
<td>Relevant reporting requirements, including how and what to report.</td>
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<tr>
<td>b.</td>
<td>Reportable diseases/conditions.</td>
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<tr>
<td>c.</td>
<td>Timeframes for reporting.</td>
<td></td>
<td></td>
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<td>If this function is carried out in full by a federal agency, other health department, or other entity, then documentation must be provided to demonstrate the health department was aware of and participated in the training or its development.</td>
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**TRAINING EXAMPLES**

The intent is to demonstrate training provided to surveillance sites, whether the materials were developed by the health department or others. Trainings or meetings may address general surveillance requirements or disease/condition-specific requirements.

Trainings or meetings could be delivered in-person, online, via webinars, or using more passive methods to share information, for example, pre-recorded videos or newsletters, etc.

**DOCUMENTATION EXAMPLES**

Documentation could be, for example, training or meeting materials (such as, minutes or slides/handouts, etc.), pre-recorded videos, online training modules, emails, newsletters, or reports.

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<tr>
<th>3.</th>
<th>Surveillance data received from two different reporting sites. Each example must address a different surveillance topic.</th>
<th>2 examples</th>
<th>2 years</th>
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<tr>
<td>If this function is carried out in full by a federal agency, other health department, or other entity, then this requirement does not apply.</td>
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The intent is to show receipt capabilities, which might include from whom data was received, when and how it was received. Personal health information (PHI) or other identifiers may be redacted.

To demonstrate different surveillance topics, the health department could provide examples from two different diseases/conditions or could include examples from vital statistics surveillance, environmental surveillance, etc.

Documentation could be, for example, reports of positive tuberculosis (TB) cases from hospitals, confirmed rabies cases from public health laboratories, a case of antibiotic resistant infection, or communicable disease reports from an assisted living facility.

**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.

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<th>Number of Examples</th>
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<tr>
<td>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.</td>
<td>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.</td>
<td>1 comprehensive policy and procedure or a set of policies and procedures</td>
<td>5 years</td>
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<td>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.</td>
<td>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.</td>
<td>Accreditation documentation, certification, or licensure appropriate for all labs used by the health department for testing</td>
<td>5 years</td>
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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 |

Measure 2.1.4 A: Maintain protocols for investigation of public health issues.

**Purpose & Significance**
The purpose of this measure is to assess that the health department has investigation protocols. Health departments require standard operating procedures, including the stepwise, standardized process of investigating public health issues and the roles and responsibilities of individuals and entities that may be involved in the investigation. A standardized approach fosters transparency and ensures thorough investigation into the cause of public health issues and timely response so that further consequences/impacts of these public health issues can be prevented.

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<tr>
<td>1. Listing of protocols for conducting investigations of suspected or identified public health issues.</td>
<td>The intent of this requirement is not to provide all protocols, but rather evidence that the protocols exist. This could be documented through a Table(s) of Contents or other listings such as a screenshot of a shared drive where policies are accessed. For required element a: Infectious conditions that may require investigation could include, for example, diseases like measles, rabies, tuberculosis, coronaviruses, etc., or sexually transmitted diseases/infections, such as chlamydia, gonorrhea, syphilis, or HIV. For required element b: Non-infectious illnesses could address, for example, chronic conditions, such as, asthma, diabetes, heart disease and stroke, or clusters of diseases like cancer. For required element c: Injury investigations could include, for example, occupational health hazards (e.g., industrial, workplace related, etc.), safety or accident investigations (e.g., falls, suicide, firearms or violence, pedestrian-related, etc.). For required element d: Environmental investigations could relate to, for example, water quality (e.g., water sampling, drinking water contamination, source investigations, etc.), food (e.g., foodborne illness, etc.), air quality (investigation of particulates or pollutants, etc.), chemical emissions or radiological hazards, or other environmental hazards (e.g.,...</td>
<td>1 comprehensive Table of Contents of protocols or listing of protocols</td>
<td>5 years</td>
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</table>
2. Investigation protocols for illnesses, environmental health issues, or injury health hazards, which must include:
   a. Assignment of responsibilities for investigations among specific staff position(s) or partner agencies.
   b. Public health issue-specific protocol steps which include:
      i. Investigation steps.
      ii. Defined timelines for each investigation step.
      iii. For reportable conditions, any applicable reporting requirements.

   One example must address an infectious illness and the other cannot address an infectious illness.

|||||
|---|---|---|
|2. | Investigation protocols for illnesses, environmental health issues, or injury health hazards, which must include: | Protocols define a set of procedures which outline the standardized approach to investigations, including established roles and responsibilities among staff and steps that will be taken, including defined timelines and reporting requirements. For example, the investigation of foodborne illness could require responsibilities among environmental health and epidemiologists and could have implications for additional staff related to enforcement or extend beyond the health department to other agencies. |
| | a. Assignment of responsibilities for investigations among specific staff position(s) or partner agencies. | For required element a: The assignment may be to a specified position or positions (for example, all environmental public health sanitary, epi-diagnostic teams, and/or community health outreach staff in the health department), a named individual, or a partner agency. This could be shown, for example, in a flow chart. |
| | b. Public health issue-specific protocol steps which include: | For required element b: Steps in the investigation protocol define how quickly the investigative activity should be completed for various steps. The coversheet may be used to indicate if reporting requirements are applicable to the investigation type. |
| | i. Investigation steps. | Tribal health departments can use their agreement with the Indian Health Service (IHS) or any other organization or entity that performs investigations on their behalf to meet this requirement. |
| | ii. Defined timelines for each investigation step. | DOCUMENTATION EXAMPLES The protocols could be, for example, in separate documents, contained in a manual format, or in a single compiled document. |
| | iii. For reportable conditions, any applicable reporting requirements. | |

Measure 2.1.5 A: Maintain protocols for containment/mitigation of public health problems and environmental public health hazards.

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

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<tr>
<td>1. Protocol or a set of protocols for nuisances, solid waste, etc.)</td>
<td>The intent of this measure is for the health department to provide written</td>
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the containment/mitigation of all health problems and environmental issues. At least one protocol for infectious illness must minimally address the process for:

- a. Case and contact management.
- b. Exercising legal authority for disease control when thresholds are exceeded.

| Protocols/procedures for how they contain or mitigate all health problems or environmental hazards. Protocols could address, for example, foodborne illness, lead investigations, etc. These protocols could be in a single document or comprised of many separate documents. At least one of the protocols for an infectious illness will include elements a and b. (Environmental hazard protocols do not need to address a and b.) For required element a: Case and contact management could include, for example, contact tracing or post-exposure notification, etc. For required element b: Exercising legal authority could be related to, for example, containment or mitigation actions, such as, school or business closure, quarantine, isolation, allocation of MCMs, or regulation of environmental exposures. | comprehensive protocol or a set of protocols |

| The intent of this requirement is to demonstrate that the health department has considered factors which contribute to higher health risks or inequities when they implement containment/mitigation strategies in their jurisdiction. An example of an effort to assist a single individual would not meet the intent of this requirement. However, the health department could provide an example of an effort to assist, for example, a neighborhood (e.g., a community that experienced high lead levels due to old pipes) or a subpopulation (e.g., older community members if they are particularly susceptible to an outbreak). The example could also address a change in policies or procedures that would guide future containment or mitigation efforts. The examples can be from events that require formal containment/mitigation efforts (e.g., natural disasters, pandemics) or from situations that might entail more routine case and contact management (e.g., TB, STI). The health department may or may not be the lead agency and could select examples of containment/mitigation efforts developed in collaboration with others, such as, for example, Community-Based Organizations (CBOs) or Community Health Workers (CHWs) or Community Health Representatives (CHRs). Efforts could address, for example, aspects of the built environment (e.g., water quality, air pollutants, lead) or climate control in areas with high rates of poverty or historic redlining; contact tracing or STI partner notification involving individuals who are undocumented; isolation or quarantine for individuals who are unhoused; making sure people have access to groceries or essential supplies during isolation or quarantine; or addressing transportation barriers, for example, to access foodbanks, access follow-up care, | 1 example 5 years |
treatment, or receive emergency biologics or prophylaxis.

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<tr>
<th>Measure 2.1.6 A: Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.</th>
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<tr>
<td><strong>Purpose &amp; Significance</strong></td>
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<tr>
<td>1. Investigation or mitigation implemented collaboratively to address reportable conditions, disease outbreaks, environmental health issues, or occupational health hazards. The examples must be from two different events. If a health department has not had an investigation or mitigation need within the five years prior to submitting documentation, they must demonstrate that they have exercised or drilled their protocol to test how it works in their setting.</td>
<td>The intent of this requirement is to work collaboratively on an investigation or mitigation, <strong>not</strong> to have another entity carry out the investigation on the health department's behalf. Each example will demonstrate that the health department has worked with at least 1 other entity to conduct an investigation or mitigate a public health problem or environmental public health hazard. Examples could include working with schools or working with a neighboring local, Tribal, or military health department on an investigation that crosses jurisdictional boundaries. For Tribal health departments that have not had an investigation need within the timeframe, drills performed by IHS or Tribal Epidemiology Centers can be used for documentation, if the health department can describe how they participated in the drills. <strong>DOCUMENTATION EXAMPLES</strong> Documentation could include investigation reports and records, After Action Reports, meeting minutes, presentations, or news articles.</td>
<td>2 examples</td>
<td>5 years</td>
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<tr>
<th>Measure 2.1.7 A: Use surveillance data to guide improvements.</th>
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<tbody>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
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</table>
1. Reports generated from an infectious disease reporting system to demonstrate completeness of reporting. Reports must include:
   a. Conditions.
   b. Dates associated with investigations.
   c. Investigation results.
   Each example must address a different reportable/notifiable condition.

   If the health department does not have access to pull reports from a system, an explanation must be provided which addresses the process for a-c.

   The intent is to demonstrate the reporting and investigation of infectious conditions according to defined timelines.

   Both examples could be included on the same report, if the reporting system includes a log with multiple reportable/notifiable conditions. A single investigation report with details could be used for each example, if the reporting system does not contain capabilities to generate a summary of multiple investigations.

   Documentation could include excerpts of reports generated by others, so long as the data pertains to the jurisdiction or population served.

   For required element a:
   Conditions could include, for example, infectious diseases such as measles, rabies, tuberculosis, coronaviruses, etc., or sexually transmitted diseases/infections, such as chlamydia, gonorrhea, syphilis, or HIV, etc.

   For required element b:
   Dates will include the dates associated with steps in the investigation process (e.g., incident date, referral date, lab test result date, investigation attempt date, investigation close date, reporting condition to state/federal date, etc.).

   For required element c:
   Investigation results could indicate for example, whether the case was probable, suspect, confirmed, not a case. Investigation results could be referred to in different terms (e.g., case status, case classification status, etc.).

2. Surveillance data used to identify differences in population groups.

   The intent is to examine aggregated surveillance data to identify patterns, trends or disparities across the population served by the health department. Data may be disaggregated and analyzed by condition (infectious or non-infectious). For example, the surveillance data could be specific to heart disease and disaggregated by demographics, geography, or other factors. Data could also be disaggregated by population or sub-population, for example, analyzing immunization rates among school aged children to identify sub-populations or groups requiring vaccination. The analysis could consider, for example, differences in the prevalence or incidence of disease, or other patterns or trends, etc. Analysis could also consider root causes or contributing factors that influence health status. For example, environmental surveillance datasets could be analyzed to consider implications related to climate change or environmental justice.

   **DOCUMENTATION EXAMPLES:**
   Documentation could be, for example, an excerpt of a report, which may be surveillance data included in the CHA, seasonal influenza or other communicable disease, or other epidemiology report; or meeting materials or presentations showing use of surveillance data to identify differences in population groups.
3. Surveillance data used to improve surveillance system or containment/mitigation strategies.

The intent of this requirement is to demonstrate how the health department uses data from surveillance systems to inform improvements in either the surveillance system itself or in containment or mitigation strategies.

Surveillance system improvements could include, for example, using data to identify which surveillance site partners are not transmitting reports through the electronic reporting system to improve timeliness of receiving reports; or improving data analysis or reporting processes.

Improvements in mitigation strategies could be, for example, related to contact management processes, emergency biologics or prophylaxis, processes to exercise legal authorities, outbreak management practices, or targeted outreach to increase vaccination rates among populations with lower rates.

The disaggregated surveillance data from Required Documentation 2, which identify differences in population groups, could also be used to drive the improvement.

Improvement efforts could be formal, such as a quality improvement project or could use less formal methods. Regardless of the improvement methodology, the examples will demonstrate how data were used to inform the improvement. If the data themselves are not included in the example, a memo or coversheet may be used to provide a description of the data collected and how it was used.

Measure 2.1.8 S: Communicate about and support investigations at the Tribal or local level.

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication from the state health department to the Tribal or local health department(s) when the state health department led an investigation in that jurisdiction.</td>
<td>The intent of this requirement is to show how the state health department provided communication to Tribal or local health departments, which could include, for example, correspondence on the status of suspected or confirmed health hazards and the status of investigations or findings. DOCUMENTATION EXAMPLES Documentation could include, for example, correspondence to Tribal or local health department(s) on a suspected or confirmed case(s) or outbreak(s) within their jurisdiction so</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>
If the investigation spans multiple jurisdictions, the example must show how the state health department communicated with all the local and Tribal health departments affected. That they are apprised of the investigation. Documentation could also include, for example, a completed investigation report or After Action Report (AAR) for an actual event showing interaction with Tribal or local health departments during the event.

<table>
<thead>
<tr>
<th>2.</th>
<th>Support provided to be responsive to the needs of a Tribal or local health department when that Tribal or local health department was taking the lead on an investigation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support could be provided, for example, through general guidance, advice or protocols to Tribal or local health departments performing the investigation; or actual involvement in the investigation process by coordinating supplies or equipment or sending appropriate staff (e.g., environmental or epidemiologists, or other subject matter experts). The intent of this requirement is to demonstrate that the state health department was responsive to the needs of Tribal or local health departments when the Tribal or local health department led an investigation.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

**DOCUMENTATION EXAMPLES**

Documentation could include, for example, documentation that the state health department deployed staff to a Tribal or local health department to assist with an investigation; emails or meetings showing the guidance and support the state health department provided; or After Action Reports or other debriefs of investigations, or investigation reports showing how the state health department supported Tribal or local health departments.

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. The state may not be able to meet all requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful.

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**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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
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<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
<td>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 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,</td>
<td>1 plan</td>
<td>3 years</td>
</tr>
<tr>
<td>Measure 2.2.2 A: Implement administrative preparedness practices to ensure continuity of operations and rapid response.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose &amp; Significance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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. |
| 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, 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). |
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

<table>
<thead>
<tr>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Continuity of operations plan,</strong> which must include:</td>
<td>1 plan</td>
<td>5 years</td>
</tr>
<tr>
<td>a. Identification of essential public health functions that must be sustained during a continuity event.</td>
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<td></td>
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<tr>
<td>b. Orders of succession.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Identification of an alternate location for key health department staff to report, if necessary, or the ability to work virtually.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. The process for expedited administrative procedures used during a response to an event that</strong></td>
<td>1 process</td>
<td>5 years</td>
</tr>
<tr>
<td>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.</td>
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</tbody>
</table>
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 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 2.2.3 A: Maintain access to trained personnel and infrastructure services for surge capacity.

**Purpose & Significance**
The purpose of this measure is to assess the health department’s ability to access necessary equipment and to engage and train personnel in surge situations. Access to trained personnel, requisite infrastructure, and laboratory services is critical when the capacity for response to an emergency exceeds normal health department capacity.
<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inventory or other documentation which details types of equipment necessary for responding to an emergency that exceeds the health department’s capacity and how they are accessed.</td>
<td>The intent of this requirement is that the health department has access to additional equipment and physical resources in a surge (e.g., transportation, communications, software for volunteer management, PPE, etc.). Equipment available for surge could include, for example, modes of transportation like trucks, vans, or trailers; heavy machinery; radios or walkie talkies; laptops; personal protective equipment like face masks or goggles; or tables and chairs. The health department could also include resources for additional infrastructure such as use of physical spaces like auditoriums or gymnasiums, etc. The health department will indicate how it accesses the equipment by either describing where the equipment is located or if it is available through a MOU/mutual aid agreement. DOCUMENTATION EXAMPLES: Documentation could include, for example, lists, spreadsheets, screenshots of electronic inventory databases.</td>
<td>1 inventory, list, or other documentation</td>
<td>5 years</td>
</tr>
<tr>
<td>2. Protocols for engaging personnel in a surge scenario, that must minimally include the following:</td>
<td>The intent of this requirement is that the health department has proactively identified what positions will be required in a surge response, and how surge roles will be filled. Identifying personnel for surge capacity could include additional roles beyond laboratory, epidemiological, and environmental personnel, such as nurses, health educators, disease investigators, communications specialists or PIO support, logistics or information technology support, or administrative personnel. The protocol could include external surge personnel, such as Medical Reserve Corps, Epi-Aid, students, other volunteers, etc., in addition to paid staff. The protocol could be contained in the Public Health EOP or be part of a separate or different plan or protocol. For required element a: The health department will describe its process for how it will maintain a list of whom to contact for surge personnel. If surge personnel are available through MOUs or mutual aid agreements, the protocol will list those agreements. If the health department maintains a list of specific personnel who are available for surge, the process could include, for example, how the health department periodically reviews the list to ensure contact information is current. For required element b: Surge personnel could be notified, for example, through an alert or notification system, or other contact management process, such as by phone or email.</td>
<td>1 comprehensive protocol, or set of protocols, and/or written agreement(s)</td>
<td>5 years</td>
</tr>
</tbody>
</table>
department operates a public health laboratory), epidemiological, and environmental personnel. If the health department does not operate public a health laboratory, it can be indicated on the coversheet.

For required element c:
Personnel could be informed of their roles and responsibilities during a briefing, for example, which might address pertinent information such as the current status of the emergency, how the volunteer is to operate within incident management, job action sheets, or roles and responsibilities assigned based on necessary skills, knowledge, and credentials as applicable, for established volunteers. The procedures could also address how roles and responsibilities would be provided to spontaneous volunteers, or those who request to be part of supporting response efforts, are triaged and incorporated with other volunteer resources.

For required element d:
Safety considerations for surge personnel could consider, for example, medical, environmental exposure, or mental/behavioral health risks responders might encounter. Procedures could address, for example, establishing a Safety Officer or subject matter experts to provide health and safety recommendations; distributing safety materials (e.g., basic or risk-related personal protective equipment); providing training among surge personnel on proper use of safety equipment; or establishing processes for area providers to provide medical or mental/behavioral care for surge personnel.

3. A schedule for training or exercises to prepare personnel who will serve in a surge capacity, which includes at a minimum ICS 100, 700, and 800 training.

Preparedness for surge personnel does not have to be the sole focus of the trainings or exercises but must be an identifiable component of the trainings.

The schedule may be part of the Public Health EOP, the health department’s workforce development plan, or may be a standalone schedule of training and/or exercises. At a minimum, the schedule for training includes ICS 100, 700 and 800 training.

While all personnel that will serve in a surge capacity need basic training, additional training as appropriate for the surge position may also be included on the training schedule. In addition to ICS, the schedule may include additional ICS courses, NIMS training, topics like fit testing for N95 masks or guidance on how to use other personal protective equipment, an overview of the Strategic National Stockpile (SNS), or surge-position specific training for those identified as surge personnel.

**DOCUMENTATION EXAMPLES**

Documentation could be, for example, an excerpt of the Public Health EOP or workforce development plan, or a spreadsheet or other schedule of surge training options, etc.

| 1 training schedule | 5 years |

4. Proactive, or just-in-time training.

If no proactive/just-in-time trainings have been conducted within the last 5 years, a description of how just-in-time trainings would be provided, will suffice.

The intent is not to provide a routine training (as addressed in the training schedule topics from Required Documentation 3), rather proactive training, or “just-in-time” training, provided as immediate instruction or information to responders (e.g., key personnel or volunteers) with critical information, such as, specific roles and responsibilities (e.g., job aids or position or function specific duties), deployment resources (e.g., checklists, tools, or other templates), or the latest information on the current status of the situation.

The coversheet will briefly describe the emergency, event, etc., providing context for 1 example 5 years
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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
</table>
| 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.  
  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. |  
  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 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 | 1 plan | 5 years |
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.

during an emergency. 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.

<table>
<thead>
<tr>
<th>2. Methods implemented to communicate with the public during an emergency.</th>
<th>The intent of this requirement is to demonstrate multiple methods of communicating with the public during an emergency.</th>
</tr>
</thead>
<tbody>
<tr>
<td>One example must demonstrate how the department worked with the news media to disseminate information during a public health emergency.</td>
<td>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.</td>
</tr>
<tr>
<td>The other example must demonstrate use of social media.</td>
<td>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.</td>
</tr>
</tbody>
</table>

| 2 examples | 5 years |
that requires special communication considerations.

If no emergencies have occurred within the last 5 years, the health department can indicate that in the coversheet.

**DOCUMENTATION EXAMPLES:**

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

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### 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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An emergency communication protocol, process, or system for contacting response partners 24/7 during a public health emergency, which must include:</td>
<td>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 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</td>
<td>1 comprehensive or set of protocols or processes</td>
<td>5 years</td>
</tr>
</tbody>
</table>
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.

   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

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**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)

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
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<tbody>
<tr>
<td>1. A plan for conducting response exercises, which indicates how the elements in the EOP or annexes have been or will be tested.</td>
<td>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.</td>
<td>1 plan</td>
<td>5 years</td>
</tr>
</tbody>
</table>
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. 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 change.

   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.

| Measure 2.2.7 S: Provide communications and other support to Tribal and local health departments related to response efforts. |
| Purpose & Significance |

Page 38 of 131
The purpose of this measure is to assess the state health department’s support of Tribal and local health departments in the state in preparing for and responding to emergency situations. State health departments provide critical support to Tribal and local health departments by providing guidance and information to Tribal and local health departments to ensure effective response. Tribal and local health departments are partners in providing a public health response to an emergency. State health departments will share information concerning the state’s key policies or actions during the emergency to ensure optimal coordination. State health departments may also be in a position to share communications and information received from the federal level.

<table>
<thead>
<tr>
<th>Required Documentation</th>
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<th>Number of Examples</th>
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<tbody>
<tr>
<td>1. Support provided to Tribal or local health departments to be responsive to their needs in developing and testing emergency operations plans.</td>
<td>Support includes the provision of information, discussion, guidance through, for example, blast faxes, webinars, emails, briefing papers, meeting minutes, distributed sample protocols, newsletters, trainings, conference calls, and documented phone calls. The intent is that the support be provided based on Tribal or local health department needs, rather than a one time or one-way communication. 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 suggestion made by the Tribal or local health department on a phone call, or a need identified during a meeting. The state may not be able to meet all requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
<tr>
<td>2. A description of how systematic communications were used to ensure all Tribal and local health departments are aware of policies or actions affecting their jurisdictions taken by the state health department during an emergency. If no emergencies have occurred within the last 5 years, documentation could be from a drill or exercise to test communications.</td>
<td>The intent of this requirement is to describe the steps the state health department took to ensure all Tribal and local health departments were informed during an emergency about key policies or actions the state takes that affect their jurisdictions. The nature of the policies or actions will determine which Tribal and local health departments are part of the communications. For example, if a natural disaster affects only one region of the state, the communications may be limited to those jurisdictions. However, state-wide policies implemented during an emergency will be communicated to all health departments within the state. The description may be included on the coversheet or may be within other documentation such as a summary report, AAR, etc. The description could include, for example, how daily or weekly meetings with representatives from all health departments in the state were instituted, how an intranet that includes the most recent resources was established, when policies/procedures to ensure that local and Tribal health departments were made aware of any state-level orders and policies before they were released to the public, including representatives from Tribe(s) in the state’s operations center or establishing a liaison between Tribal and state jurisdictional operations centers, etc.</td>
<td>1 example</td>
<td>5 years</td>
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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.

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<tr>
<td>1. Procedures for ongoing, non-emergency communications.</td>
<td>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</td>
<td>1</td>
<td>5 years</td>
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<tr>
<td>The procedures must:</td>
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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.

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 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,
<table>
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<tr>
<th>Element</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>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 organizations, 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. 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.</td>
</tr>
<tr>
<td>2.</td>
<td>Capacity to communicate with individuals who are: a. Non-English speaking, b. Deaf or hard of hearing, and c. Blind or have low vision. If the service is outside of the health department, the health department must show a current (non-expired) written agreement (contract, MOA/MOU, etc.) that demonstrates access to such service. 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; 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.</td>
</tr>
<tr>
<td>3.</td>
<td>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</td>
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</table>
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.

**Measure 3.1.2 A: Establish and implement a department-wide brand strategy.**

**Purpose & Significance**

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

**Required Documentation**

1. A department-wide brand strategy that includes policies or procedures for each of the following:
   a. Convey the health department’s brand, which demonstrates the presence of the health department, its functions, and services to the entire community.
   b. Ensure that department staff have a clear understanding and commitment to the brand of the health department.
   c. Integrate brand messaging into department communication strategies.
   d. Use a common visual identity (logo) to communicate the health department’s brand.

**Guidance**

The intent of this requirement is to outline the standardized approach used by the health department to convey its presence in the community. The health department’s brand conveys both its identity and personality, inclusive of its culture, norms, and values. Community members should not only be aware of the existence of the health department through a common visual identity, but the brand strategy should foster a positive reputation and trust among community members.

Examples of how the branding strategy has been implemented would *not* meet the intent of this requirement, as implementation examples are covered under Required Documentation 3. If programs within the department have developed program specific logos, these may be included, as part of the overall branding strategy. PHAB understands that Tribes often use the same logo or Tribal seal throughout the entire Tribe. If that is the case, PHAB will accept that as the organizational branding.

For required element a:

Branding communicates what the health department stands for and what it provides that is different from other agencies and organizations. Branding can help to position the health department as a valued, effective, trusted leader in the community. Aligning the branding strategy with the health department’s strategic plan can help highlight the role the health department plays in the community. The brand strategy could address, for example, how public health functions promote, protect, and improve the health of the entire community through a population-based lens or upstream approach.

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<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. A department-wide brand strategy that includes policies or procedures for each of the following:</td>
<td>The intent of this requirement is to outline the standardized approach used by the health department to convey its presence in the community. The health department’s brand conveys both its identity and personality, inclusive of its culture, norms, and values. Community members should not only be aware of the existence of the health department through a common visual identity, but the brand strategy should foster a positive reputation and trust among community members. Examples of how the branding strategy has been implemented would <em>not</em> meet the intent of this requirement, as implementation examples are covered under Required Documentation 3. If programs within the department have developed program specific logos, these may be included, as part of the overall branding strategy. PHAB understands that Tribes often use the same logo or Tribal seal throughout the entire Tribe. If that is the case, PHAB will accept that as the organizational branding. For required element a: Branding communicates what the health department stands for and what it provides that is different from other agencies and organizations. Branding can help to position the health department as a valued, effective, trusted leader in the community. Aligning the branding strategy with the health department’s strategic plan can help highlight the role the health department plays in the community. The brand strategy could address, for example, how public health functions promote, protect, and improve the health of the entire community through a population-based lens or upstream approach.</td>
<td>1 policy, procedure, or set of policies or procedures</td>
<td>5 years</td>
</tr>
</tbody>
</table>
For required element b:
In order to encourage all staff to have a commitment and understanding of the brand, the policy/procedure could include, for example, providing staff training (perhaps, as part of the orientation process or refresher) on developing an elevator speech on what public health is, its purpose, and role in the community; steps for sharing the written policy; staff training on the strategy; checklists for use of the brand with policy for who should use and when, etc. The focus on promoting the population’s health can also be infused by intentional policies to promote employees’ health. Modeling that aspect of the health department’s brand within the organization, could foster staff commitment.

For required element c:
The policy/procedure could, for example, discuss how the brand messaging should be integrated into communications such as website, media releases, public service announcements, social media activities, speeches, grant applications, and promotional materials, etc. Brand messaging could include, for example, the health department’s mission, vision, values, or positioning statement. Communications strategies consider the community in determining the best way to define and deliver its messages (e.g., to determine which “voice” may be most effective).

For required element d:
The policy/procedure could include, for example, guidelines on how and where to use the department logo.

2. Implementation of the department-wide brand strategy externally. Each example must address both of the following elements described in Required Documentation 1:
   a. Integrate brand messaging into department external communication strategies.
   b. Use a common visual identity (logo) to communicate the health department’s brand.

Examples will demonstrate how the brand strategy from Required Documentation 1 communicates the value of health department products, services, and practices, externally. Examples of a logo on its own would not meet the requirement as the examples will also include brand messaging.

Documentation should reflect actual use of brand messaging and the logo, for example, on a website, brochure, or other materials, rather than templates (e.g., blank letterhead).

**DOCUMENTATION EXAMPLES:**
Documentation could include, for example, branding integrated into screenshots of the health department’s website, public service announcements, media releases, social media, etc.

3. Signage displaying the brand/logo. One example must be signage inside and one example must be signage outside the health department facility.

**DOCUMENTATION EXAMPLES:**
Documentation could be, photos of the inside and outside of the health department showing use of the logo or brand strategy (defined by the health department within Required Documentation 1). If the health department operates from multiple/satellite locations, the photos could include additional offices, but must show the main office.

Measure 3.1.3 A: Communicate what public health is, what the health department does, and why it matters.

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

### Required Documentation

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<tr>
<th>Guidance</th>
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<th>Dated Within</th>
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</table>
| 1. Communications about:  
  a. What public health is.  
  b. What the health department does.  
  c. Why it matters.  
One example must show communication to the public and the other must show communication to the governing entity.  
The intent is that the health department provide information to the public, stakeholders, and governing entity about the importance of the health department and public health that fosters understanding about public health and its contributions. Messaging about how the public is part of public health can help populations better understand the personal collective responsibilities of a healthy community and may be used within the example to demonstrate what public health is and/or why it matters.  
Information about a single health department program or service would not meet the intent.  
For required element c:  
Messaging may relate to either why public health matters or why what the health department does matters.  
Tribal health department examples of distribution to a governing entity could include Tribal advisory committees and others that advocate for Tribes or comments to federal, state or other advisory committees. Submissions from the Tribe's Legislative Advisor are acceptable forms of documentation. Documentation could be presentations, letters, or fact sheets to Tribal leaders.

- **DOCUMENTATION EXAMPLES**
  - Documentation could include, for example, a copy of a presentation, advertisements or newspaper inserts, web posting, social media posts, op-eds, health department brochure, or services directory.

### Measure 3.1.4 A: Use a variety of methods to make information available to the public and assess communication strategies.

**Purpose & Significance**
The purpose of this measure is to assess the health department's use and assessment of a variety of methods and formats to keep the public informed about public health and environmental public health issues, health status, public health laws, health programs, and other public health information. Health departments need to present public health information to different audiences through a variety of methods, including the use of social media. Health departments should assess their communications efforts to understand how well they are reaching community members.
### 1. The health department’s website or web page URL. The website will be assessed for the following elements:

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<th>Required Element</th>
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<tr>
<td>a. 24/7 contact number for reporting health emergencies.</td>
<td>The intent of this requirement is to disseminate information on public health issues to the broadest audience possible. The health department may have its own website or have designated pages on another governmental website or internet domain. Required elements will be verified by the Site Visit Team, which will review the health department website; screenshots are not required. A coversheet will be provided to navigate to each of the required elements.</td>
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<tr>
<td>b. Notifiable/reportable conditions link or contact number.</td>
<td>For required element a: The intent of this requirement is that a number be specifically provided that indicates how to contact the health department during emergencies, 24/7. This could be through an answering service or another entity for after hours.</td>
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<tr>
<td>c. The jurisdiction’s community health assessment and community health improvement plan.</td>
<td>For required element b: The link or number to report notifiable/reportable conditions could be the same number as the 24/7 contact number for reporting emergencies or could be a different number/link.</td>
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<tr>
<td>d. Public health data specific to the health department’s jurisdiction.</td>
<td>For required element d: The web page could include, for example, links to factsheets, data reports, morbidity and mortality data, social determinants data, dynamic incidence and prevalence data, etc. Data could be collected by others, for example, school district, police, local institute of higher education, etc.</td>
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<tr>
<td>e. Links to public health-related laws or codes including enforcement related laws.</td>
<td>For required element g: Information and materials from program activities could include, for example, infectious disease, chronic disease, environmental public health, prevention, and health promotion.</td>
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<tr>
<td>f. Links to permits/license applications.</td>
<td>For required element k: The method(s) provided on the website for the public to provide comments or feedback could be an email address, a text box, a feedback survey, or other method.</td>
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<tr>
<td>g. Information about and materials from public health program activities conducted by the department.</td>
<td>For required element l: Website updates could be demonstrated through, for example, “last updated” dates posted on the webpage, emails with IT staff, or other documentation demonstrating an update has occurred within the timeframe requirement.</td>
</tr>
<tr>
<td>h. Links to CDC and other public health-related federal, state, or local agencies, as appropriate.</td>
<td>Tribal health departments can decide through what means they make public health data available to their population or community, including required elements c and d. Data do not need to be posted on the Tribal health department website. If the Tribal health department does not post public health data, that should be indicated on the coversheet.</td>
</tr>
<tr>
<td>i. The names of the health department director and the department’s leadership team.</td>
<td></td>
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<tr>
<td>j. The address of the health department.</td>
<td></td>
</tr>
<tr>
<td>k. A method for the public to submit comments to the health department.</td>
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<tr>
<td>l. Evidence of at least one update to the website within the past 14 months.</td>
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### 2. Social media used to provide information to the general public about public health issues or health department functions.

Social media provides additional mechanisms to share information about the health department, its programs and activities, and health promotion messages with the public, while facilitating communication (social networking). Common social media platforms include, but are not limited to: Facebook, Twitter, LinkedIn, Instagram, Pinterest, etc. Both examples provided
Standard 3.2
Use health communication strategies to support prevention and wellness.

Measure 3.2.1 A: Design communication strategies to encourage actions to promote health.

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

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<tr>
<td>1. A department-wide approach for developing and implementing communication strategies designed to encourage actions to promote health.</td>
<td>The intent of this requirement is to show the department-wide approach or framework for communications designed to inspire behavior change, rather than a single program or area, in order to develop consistent health messaging. This does not need to be prescriptive or formalized into a separate plan or policy/procedure but could be demonstrated through a checklist or training materials which support health communication planning and strategies. Unlike the health department’s overall communications procedures (which will be inclusive of</td>
<td>1</td>
<td>department-wide approach</td>
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</table>
The planned approach must include processes for:

a. Determining that an issue is a priority for communication efforts.

b. Identifying appropriate evidence-based or promising practices.

c. Engaging the priority population(s) in the design, development, or implementation of strategies.

d. Ensuring consistency with procedures for communications (Measure 3.1.1) about:
   i. Ensuring information is accurate and timely.
   ii. Tailoring communication for different audiences.
   iii. Informing or coordinating with community partners to promote the dissemination of unified public health messages.

For required element a:
Determination of priorities could include, for example, selection based on the identification of priority populations that are at higher risk for poorer health outcomes. Sources of information could include, for example, community health assessment or improvement plan, surveillance or other data sources, or community input, etc. The approach (e.g., checklist or training) may indicate what sources the health department consults in determining priorities or may describe what the prioritization process entails.

For required element b:
The approach might describe what resources the health department consults to identify if there are evidence-based or promising practices that meet the needs for a particular communications strategy or how the health department considered how evidence-based practices were tailored to the population or target audience. Due to the limited availability of evidence-based practices or promising practices in Tribal communities, Tribes may identify methods to adapt models or create models based on a cultural framework.

For required element c:
The approach could describe processes by which input from the priority population(s) is used to help shape the content, dissemination, or implementation. For example, considering social, cultural, and/or faith aspects could shape the content and delivery methods, such as, engaging representatives from the priority group in message delivery or use of social media when engaging youth. Community input may be used to help a health department determine which existing communication materials are appropriate for efforts to provide information to the public, this approach will focus specifically on efforts that are designed to encourage members of the public to consider taking particular actions.

Health communication strategies should be designed for effectiveness, as rooted in sound theory, based on available evidence-based, practice-based, and/or promising practices. At the same time, to be effective, health communication strategies may take into account input from the priority population to ensure strategies are provided in a manner that can be easily understood and is most likely to have an impact. There may be times when these two goals—following an evidence-based practice and tailoring the strategy to the priority population(s)—are in tension. In other words, because an evidence-based education program has already been tested and validated, it may be appropriate to implement it as it was designed. For example, health departments might select an evidence-based tobacco campaign that was designed for youth through the use of social media or videos/PSAs using youth voices. Alternatively, evidence-based sexual health or vaccination messaging or modes may require tailoring to address social, cultural, or faith norms. A communications approach can explain how the health department will identify if there are evidence-based or promising practices and determine if and how it is appropriate to tailor the strategies to meet the unique needs and characteristics of the community, which may vary depending on the size of the population, geography, social and other factors.
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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
</table>
| 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. | 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. | 2 examples | 5 years |
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.

<table>
<thead>
<tr>
<th>Chronic disease program areas could include, for example, diabetes, obesity, heart disease, HIV, substance abuse, or cancer.</th>
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<tbody>
<tr>
<td>For required element a:</td>
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<tr>
<td>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.</td>
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<td>For required element b:</td>
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<tr>
<td>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.</td>
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<td>For required element c:</td>
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<tr>
<td>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.</td>
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<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
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<tr>
<td>The same example could show both how an evidence-based or promising practice was used and how it was adapted based on community input.</td>
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### 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 4.1.1 A: Engage in active and ongoing strategic partnerships.**

**Purpose & Significance**

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

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<th>Required Documentation</th>
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<th>Dated Within</th>
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</table>

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
1. A collaborative activity to address specific public health issues or populations that arose because of an ongoing partnership with another organization.

   In addition to the example of the collaborative activity, the coversheet or other documentation will also include the following to demonstrate each example arose from an ongoing collaboration:
   a. Name and brief description of the partner organization.
   b. Description of how long the partnership has been in place.
   c. Description of intentional actions taken to maintain the ongoing relationship.
   d. A brief description of how the example provided demonstrates that this is a collaborative activity that arose because of the ongoing partnership.

   The health department must document 1 collaborative activity from each of two relationships with different organizations.

   The intent of this measure is to document examples of the health department engaging in ongoing strategic relationships with other organizations that resulted in collaborative activity. Coalitions the health department participates in would not meet the intent and are covered in the following measure. The health department will describe relationships with two partner organizations. For each collaboration the health department will provide documentation of one collaborative activity (e.g., a joint event, a grant application, a collaborative outreach/enrollment effort) and describe elements a-d.

   For required element a:
   The partner could be another health department (for example, a neighboring local, state, Tribal, or military health department), another governmental entity (e.g., transportation, energy, education, emergency management, aging, law enforcement, housing, community development, economic development, parks and recreation, planning and zoning), hospital or other health care provider, community foundation or philanthropist, voluntary organization, faith-based organization, community organizer or advocacy organization, business, chamber of commerce, academic institution, local death review organization, public health institute, environmental public health group, group that represents minority health, etc.

   For required element b:
   The partnership may have been established more than 14 months before documentation submission. It is the example of the collaborative activity that will be dated within 14 months of documentation submission.

   For required element c:
   The intent of this element is to show that the health department has taken deliberate steps to maintain an ongoing relationship. That is, ongoing interaction to build trust and familiarity over time to facilitate new collaborative activities. This could include, for example, establishing monthly or quarterly meetings; establishing data sharing agreements; colo-locating services with another organization; having staff of the health department serve on an advisory group for the other organization or vice versa; having health department staff go through orientation or training at the other organization or vice versa; or explicitly assigning a staff member as a liaison to another organization.

   For required element d:
   The intent of this element is to demonstrate that this is an ongoing relationship that leads to other opportunities for engagement. For example, if a health department had an ongoing relationship with a school district to enroll families in food assistance programs, that may lead to an opportunity for the health department to participate in a review of nutritional offerings in the cafeteria. Similarly, a health department with an ongoing relationship with an FQHC to enroll clinic patients in WIC, might have been able to build on that relationship to collaborate on a vaccine clinic.
**Measure 4.1.2 A: 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. Coalition(s) provide the opportunity to leverage resources, incorporate various perspectives and expertise, coordinate activities, and employ community assets in new and effective ways. Coalition(s) include engagement with community members so that they are involved in the process and participate in the decisions made and actions taken.

### Required Documentation

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<tr>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</table>
| 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.  
  e. Modes and frequency of interaction.  

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.  

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: | 2 examples of topic/population specific coalitions or one example of a coalition that works on 2 or more issues | 2 years |
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.

<table>
<thead>
<tr>
<th>Measure 4.1.3 A: Engage with the community to address public health issues and concerns.</th>
<th>2 examples</th>
<th>5 years</th>
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</thead>
<tbody>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
<td>The purpose of this measure is to assess the health department’s authentic engagement with community members to partner with them in addressing public health issues and concerns. Community engagement is an ongoing process of dialogue and discussion, collective decisions, and shared ownership. Public health</td>
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improvement requires social change; social change takes place when the population affected by the problem is involved in the solution. Community engagement also has benefits of strengthening social engagement, building social capital, establishing trust, ensuring accountability, and building community resilience.

### Required Documentation

1. Strategies implemented to promote active participation or eliminate barriers to participation among community members.

   The intent of this measure is to demonstrate specific actions the health department has taken to encourage participation of community members in addressing public health issues, particularly efforts to empower populations whose voices might not otherwise be heard to co-lead efforts to improve community health. Strategies may be led by the health department or the health department might participate in these strategies in partnership with others.

   Examples of strategies could include:
   - Implementing a leadership/civic engagement academy that gives community members the opportunity to build their capacity.
   - Offering mini-grants to support community-led initiatives.
   - Engaging in participatory budgeting (e.g., letting community members participate in decision making about how to allocate a set amount of financial resources).
   - Providing transportation mechanisms to increase participation by community members or providing incentives such as childcare or stipends.
   - Changing the decision-making structure to empower community members.
   - Supporting grassroots interventions and initiatives with access to funding or eliminating barriers by changing institutional culture to provide access to community leadership or buy-in.
   - Ensuring consistency and transparency in how the health department engages with the community, such as, creating space for community participation on workgroups or establishing systems or structures to include community-led initiatives.

**DOCUMENTATION EXAMPLES**

Documentation could include, for example, a summary or report; meeting minutes describing the implementation; news articles; etc. If appropriate, the documentation could be supplemented by a description in the coversheet—for example, to describe that how the strategy was implemented consistently.

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### Domain 5:

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

### Standard 5.1
Measure 5.1.1 A: Maintain knowledge of public health issues that are being discussed by those who set policies and practices that impact on public health.

Purpose & Significance
The purpose of this measure is to assess the health department’s ability to maintain knowledge and awareness about what policies and laws are being considered and their impact on public health. This could enable the health department to influence the development of those policies. An important role for health departments is influencing the adoption of effective public health policies and laws by being a resource for science-based public health information. Health departments should be aware of current and proposed policies, including implications to health, and may use a Health in All Policies (HiAP) approach.

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<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</table>
| 1. Evidence that the health department stays informed of the public health issues that are being discussed by the health department’s governing entity, elected officials, or other individuals or entities that set policies and laws that impact public health or the health department. | The intent of this measure is to show how the health department is aware and informed of issues under consideration by the governing entity, elected officials, or entities that set policies and laws (including regulations, ordinances, etc.). Policies being discussed could be Tribal, state, federal, or local.  

Local elected officials include county (e.g., county manager, board of commissioners, or supervisors) or city officials (e.g., mayor, city council, board of commissioners, or supervisors). State elected officials include the governor, council of state, or state legislators. Tribal elected or appointed officials vary depending on the Tribal Nation’s governance. Some examples include: Principal Chief, Chief, President, Chairman/ woman/person, Governor, Tribal Council Member, or Health Oversight Committees. Government officials include elected or appointed positions or other staff of government departments (e.g., education, labor, insurance, etc.). Health departments may also indicate how they are tracking federal policies that will have implications in their jurisdiction.  

Consistent with a Health in All Policies approach, these policies or laws could include those related to, for example, education, transportation, or other sectors that could have an effect on the public’s health or on health equity.  

They may also be policies or laws that have a direct effect on the operations of the health department (e.g., changes that may affect the health department’s budget or workforce) or that would affect the ability of the health department or a governing entity to issue or enforce a public health order, because these proposals affect the health department or its governing entity’s ability to effectively promote and protect the public’s health. | 2 examples | 2 years |
### 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.

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<th>Required Documentation</th>
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<th>Number of Examples</th>
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<tr>
<td>1. Findings from a review of current or proposed policies or laws shared with 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.</td>
<td>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 those who set or influence policies. Policies that only affect the health department’s internal operations (e.g., HR policies) do <strong>not</strong> 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.</td>
<td>2 examples</td>
<td>5 years</td>
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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 5.2.1 A: Engage partners and members of the community in a community health improvement process.**

**Purpose & Significance**

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

**Required Documentation**

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<tr>
<th>Number of Examples</th>
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<tbody>
<tr>
<td>1 process</td>
<td>5 years</td>
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<table>
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<tr>
<th>1. A collaborative health improvement planning process, which includes:</th>
<th>Guidance</th>
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<tbody>
<tr>
<td>a. A list of participating partners involved in the CHIP process. Participation must include:</td>
<td>The health improvement process could be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources, Mobilizing for Action through Planning and Partnerships (MAPP, developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), and the University of Kansas Community Toolbox. Examples of tools or resources that can be adapted or used include Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards (NPHPS), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2030, County Health Rankings, or innovation processes such as design thinking. The process may be included within the health improvement plan itself or may be documented through a set of meeting minutes, presentations, or other written description of the process. For required element a: Partners are organizations that work with the health department on health issues and could include other governmental agencies, not-for-profit groups, associations, special interest groups related to health assessment priority areas, education advocates, businesses, recreation organizations, faith-based organizations, etc. Partners could also include, for example, 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. Members of</td>
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<tr>
<td>i. At least 2 organizations representing sectors other than public health.</td>
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<tr>
<td>ii. At least 2 community members or organizations that represent populations that are disproportionately affected by health risks or poorer health outcomes.</td>
<td></td>
</tr>
<tr>
<td>b. Review of information from the community health assessment.</td>
<td></td>
</tr>
<tr>
<td>c. Review of the causes of disproportionate health risks or health outcomes of specific populations.</td>
<td></td>
</tr>
<tr>
<td>d. Review of national and other level of health department improvement priorities (state/Tribal/local).</td>
<td></td>
</tr>
<tr>
<td>e. Prioritization process used by participants to select priorities.</td>
<td></td>
</tr>
</tbody>
</table>
this group may or may not be the same as members of the community health assessment partnership. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees.

Membership should consider representation from those with disproportionate health risks or health outcomes (e.g., aging or minority populations, or those living in poverty). To empower individuals to participate in the assessment—and ultimately the improvement—of health in their jurisdictions, the list of partners may also include community members. Individuals or organizations that represent populations with higher health risks or poorer health outcomes could include, for example: groups that represent minority health, historically excluded or marginalized population groups, aging populations (e.g., local, state, and/or regional aging networks and agencies), not-for-profits (e.g., local branches/affiliates of disease specific or issue specific advocacy groups), civic groups representing specific subpopulations, etc. The documentation will include either organizational affiliations or will indicate if individuals are community member representatives.

For required element b:
This could include, for example, meeting minutes demonstrating the community health assessment was reviewed by the CHIP partnership, or other written description describing how the health assessment findings were used in the health improvement planning process.

For required element c:
To promote equitable opportunity for health for all, CHIP partnerships could review a range of social determinants of health (which may include structural determinants or “root causes” of health inequities) and other causes for higher health risks among specific populations, such as impacts of structural racism (e.g., redlining), disparities in the built environment, inequitable distribution of social supports. Documentation demonstrating consideration of these determinants, could be, for example, a summary of partnership discussions or meeting minutes.

For required element d:
Review of national priority alignment could include using the National Prevention Strategy or Healthy People 2030; local health departments might consider priorities in their state’s health improvement plan.

For required element e:
The intent of the requirement is to describe the steps and tools used in the prioritization process. If the MAPP process is used, the description will include the specific steps and tools utilized. Tools to prioritize health issues could include, for
example, nominal group or multi-voting techniques, affinity diagrams, or
prioritization matrices (e.g., the Hanlon Method for Prioritizing Health Problems).

**DOCUMENTATION EXAMPLES**

Documentation could be, for example, an executive summary outlining the process and participants, a participant roster with meeting minutes or summaries of discussion, etc. Elements b-e can be described in the coversheet.

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**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**

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 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</td>
<td>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, 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</td>
<td>1 plan</td>
<td>5 years</td>
</tr>
</tbody>
</table>
the actions taken to implement CHIP strategies.

- 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.

<table>
<thead>
<tr>
<th>Measure 5.2.3 A: Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
</tr>
</tbody>
</table>
The purpose of this measure is to assess the health department’s efforts to ensure that the strategies of the community health improvement plan are implemented, assessed, and revised as indicated by those assessments. Any plan is useful only when it is implemented and provides guidance for activities and resource allocation. Effective community health improvement plans should not be stagnant, but dynamic to reflect the evolving needs of the population served. Health departments should continuously work with multi-sector partnerships to evaluate and improve the community health improvement plan. While goals, objectives, and priorities are meant to be long range, strategies may need to be adjusted.

| **Required Documentation** |
| **Guidance** |
| **Number of Examples** |
| **Dated Within** |
| 1. Health improvement plan activities or strategies implemented. | Implementation may be done by health department staff or other partners involved in the health improvement plan. Providing a tracking document or workplan for this requirement is **not** sufficient evidence. |
| 2 examples | 5 years |

**DOCUMENTATION EXAMPLES**
Examples could include newspaper articles; photos demonstrating walking paths/no smoking signs; meeting minutes demonstrating the establishment of coalitions; notes from meetings held with policy makers and/or partners.
## Initial Standards & Measures Version 2022
### September 2021

| 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. |

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. An annual review of progress made in implementing all strategies in the community health improvement plan.</td>
<td>The intent is to show a full review of progress on all CHIP priorities and strategies. A review of one or a few strategies would <strong>not</strong> meet the intent. If no progress has been made on a strategy, this can be indicated in the report.</td>
<td>1 example</td>
<td>2 years</td>
</tr>
<tr>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation could include, for example, an annual report, a presentation shared with the CHIP partnership, written summary to accompany a tracking document, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. An example of revising the health improvement plan or its strategies as necessary based on the review in Required Documentation 2 (above).</td>
<td>Strategies may need revision based on a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. Changes should be developed in collaboration with partners and stakeholders involved in the planning process. The revisions may be in the improvement strategies, planned activities, time-frames, targets, or assigned responsibilities listed in the plan.</td>
<td>1 example</td>
<td>2 years</td>
</tr>
</tbody>
</table>

If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP. (Documentation must demonstrate the linkage between the activities стрategies and the prior CHIP. Although the prior CHIP may be more than 5 years old the implementation must have occurred within 5 years.)
1. A policy or procedure that demonstrates how health equity is incorporated as a goal into the development of programs that serve the community.

The policy or procedure 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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>5 years</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>5 years</th>
</tr>
</thead>
</table>

## 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 6.1.1 A: Maintain department knowledge of laws to promote and protect the public’s health.

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>1. Staff are trained on laws which they are programmatically required to enforce. Examples must be from two different enforcement areas. If the health department does not have enforcement authority, the examples must demonstrate staff are provided with training on how enforcement authorities are carried out by other agencies with enforcement authority to promote and protect health.</td>
<td>The intent of this requirement is training about a law that the health department enforces such as food codes, communicable disease reporting requirements, etc. Training about laws the department abides by or complies with, such as HIPAA, would not meet the intent of the measure. The training could include both general and specific aspects of public health law but will be relevant to the functions performed by staff. For example, an infectious disease nurse could be trained on laws pertaining to infectious disease reporting, rather than laws related to food program enforcement. Health departments that do not have regulatory enforcement responsibility still have a responsibility to maintain knowledge of laws that impact public health. For example, the school system may have the responsibility to ensure that all children entering kindergarten have had age-appropriate vaccinations. While the health department in this instance may not have enforcement authority, appropriate staff should be knowledgeable about how the relevant laws are carried out by other entities. Similarly, if the health department’s sanitarians conduct inspections of properties, but the housing department or code enforcement is responsible for issuing enforcement actions (such as, notices of violations, orders, etc.), health department staff should be knowledgeable about relevant laws and how they are carried out. In addition, if the health department does not play a role in inspections or enforcement of food establishments, staff who interact with the public still need to be knowledgeable about which entities play those roles so that they can make appropriate referrals for community members who contact the health department about possible cases of food-borne illness. Attendance records are not required, but a description of who received the training (e.g., all health department staff, specific divisions, etc.) should be indicated within the document or coversheet.</td>
<td>2 examples</td>
<td>2 years</td>
</tr>
</tbody>
</table>
Measure 6.1.2 A: Investigate complaints pertaining to public health regulations.

### Purpose & Significance

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

### Required Documentation

<table>
<thead>
<tr>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 comprehensive protocol or 2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>

### Guidance

1. Protocols for complaint investigations, which include steps for follow-up.

   - Examples must be from two different enforcement programs/areas or one comprehensive protocol pertaining to all enforcement programs/areas.

   - If the health department has no enforcement authority, the protocol(s) must address the process to refer concerns or complaints to the appropriate agency with authority.

   - If the health department has authority for only one enforcement program, one protocol must address that program and the other protocol must address the process to refer concerns or complaints to the appropriate agency with authority.

   The intent of this requirement is to describe what happens after receiving complaints from the public.

   Steps for follow up within the protocol could include, for example, steps to initiate investigations by logging complaints received, conducting initial investigations with reports of findings, or generating communications to regulated entities of what is needed or how to achieve compliance (e.g., a notice of violations, letters, memos, or other issuances of findings).

   If the health department has no enforcement authority, protocols could include, for example, methods to communicate or coordinate with the agency(ies) with authority (e.g., correspondence, complaint handling referral systems, or other process to prompt follow up on concerns or complaints). Health departments without enforcement authority might not receive formal complaints from the public; therefore protocols for addressing informal concerns raised to health department staff would also be appropriate. This may be included within an MOU or agreement or may be less formal documentation.

2. Steps taken to investigate complaints pertaining to regulated entities.

   - Examples must demonstrate that the protocols provided in Required Documentation 1 were followed.

   - Examples must be from two different enforcement areas.

   The intent of this requirement is to show implementation of the protocols to investigate complaints received (from Required Documentation 1).

   **DOCUMENTATION EXAMPLES:**

   - Documentation could be, for example, copies of complaint investigation reports. If the health department has no authority for enforcement, documentation could be, for example, letters/memos or other correspondence showing implementation of protocols to refer complaints or concerns for investigation, or coordination with other agencies during the investigation process.

   - 2 examples | 5 years
If the health department does not have enforcement authority, examples must demonstrate how the health department communicated concerns or complaints to the agency(ies) with authority based on process(es) in Required Documentation 1.

If the health department has authority for only one enforcement program, one example must address that program and the other must address communicating concerns or complaints to another agency with authority based on process(es) in Required Documentation 1.

**Measure 6.1.3 A: Conduct and monitor inspection activities of regulated entities according to a schedule.**

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Protocol/algorithm for scheduling inspections of regulated entities that defines the inspection frequency.</td>
<td>The health department may select the areas or programs. In some cases, frequency or schedule for inspections are defined by law. In other cases, the department may provide a risk analysis method in a protocol or an algorithm, which guides the frequency and scheduling of inspections of regulated entities. This could include, for example, rules requiring restaurant inspections on a specified schedule or a schedule for return inspections after a violation may be submitted. The frequency may be variable, for example, set by risk level among food establishments. <strong>DOCUMENTATION EXAMPLES:</strong> Documentation could include, for example, a protocol defining inspection frequencies or a schedule of inspection frequencies.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
<tr>
<td>2. A database or log of inspection reports that meet inspection</td>
<td>The intent of this requirement is to demonstrate tracking of inspections performed according to the frequency defined in Required Documentation 1 in the form of a</td>
<td>1 example</td>
<td>5 years</td>
</tr>
</tbody>
</table>
frequencies, as defined in Required Documentation 1. The database or log must at a minimum include:

a. Dates that inspections occurred.
b. Dates or timeframes when future inspections are scheduled.
c. Actions taken based on inspection findings.

This documentation of inspections must relate to one of the enforcement programs/areas which were provided in Required Documentation 1 above.

database or log of multiple inspection reports (as opposed to a single report) that includes dates of inspections performed, the schedule indicating dates of future inspections, and actions taken based on findings. There may be variations within the log, depending on the type of facility (e.g., food establishments may require different timeframes for follow up based on risk level) or type of violation (e.g., critical or non-critical), as timelines or actions could differ.

For required element b:
The intent of this requirement is to demonstrate the schedule for future inspections, which could be, a set date or timeframe (e.g., “in 2 weeks” or “in 1 month” or “in quarter 3”).

**DOCUMENTATION EXAMPLES:**
Documentation could include, for example, screen shots of a database with all the required elements visible, if the data are kept electronically.

**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**

<table>
<thead>
<tr>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>2 examples</td>
</tr>
<tr>
<td>2. Enforcement procedures from Required Documentation 1 implemented.</td>
<td>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.</td>
<td>2 examples</td>
</tr>
</tbody>
</table>
### 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.

**DOCUMENTATION EXAMPLES:**

Documentation 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.

<table>
<thead>
<tr>
<th>Measure 6.1.5 A: Coordinate notification of enforcement actions to share information among appropriate agencies about enforcement activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
</tr>
<tr>
<td>The purpose of this measure is to assess the health department's communication with other agencies about enforcement activities. It is important that the health department shares information concerning enforcement actions or any resulting follow-up with other agencies that have a role in educating or providing follow-up with the regulated entity. If the health department has no enforcement authority, this measure does not apply.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Required Documentation</strong></th>
<th><strong>Guidance</strong></th>
<th><strong>Number of Examples</strong></th>
<th><strong>Dated Within</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A communication protocol for how the health department notifies another agency(ies) of enforcement actions.</td>
<td>The intent of this requirement is to inform partners of enforcement actions taken by the health department. For example, the protocol to inform other agencies could be to send written correspondence notifying building and housing or code enforcement, or to the legal department regarding enforcement actions the</td>
<td>2 examples of protocols or 1 comprehensive protocol that</td>
<td>5 years</td>
</tr>
</tbody>
</table>
The health department must provide examples from two different enforcement programs/areas OR a protocol that covers multiple enforcement programs/areas.

| The health department plans to take. | An example of an enforcement program specific protocol could include, for example, sending written correspondence notifying the housing authority that the health department plans to take enforcement actions when issuing a legal notice. A protocol that covers multiple enforcement programs/areas could either address a minimum of two enforcement programs/areas or could be a comprehensive protocol covering all interagency communications. A comprehensive protocol could, for example, provide guidelines that will be followed for any notification to other agencies regarding enforcement actions. | covers multiple enforcement programs/areas |

2. An example of another agency that the health department notified of enforcement actions.

Documentation must demonstrate that protocols in Required Documentation 1 were followed.

| Documentation could include, for example, notifying other agencies through written correspondence (e.g., memos or emails), public presentations, reports, documented conference calls, etc. | 1 example | 5 years |

**Measure 6.1.6 A: Inform the public about enforcement activities.**

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A protocol for notifying the public of actions they need to take or not take based on enforcement activities.</td>
<td>The protocol may be in parts to address multiple enforcement actions, it may be a single comprehensive protocol for notifying the public concerning enforcement actions, or it may be within another protocol such as risk communications. Examples of notifications to the public could include, for example, restaurant inspection violations, emission violations, and inspections of public facilities (e.g., public swimming pools). The protocol could address notifying the public by, for example, posting enforcement actions (e.g., closures or inspection reports) to its website; placarding properties to warn the public the premises are unsafe (e.g., based on lead inspection findings, nuisances, or other hazards); signs warning public swimming pools are unsafe; press releases; etc. If the health department has no enforcement authority, the protocol could address ways the health department has helped the agency with authority to facilitate communicating enforcement actions of entities with the public. This could include, for example, sharing social media posts or website posts to help the entity with</td>
<td>2 examples or 1 comprehensive protocol that covers all enforcement programs/areas</td>
<td>5 years</td>
</tr>
</tbody>
</table>
should or should not take. enforcement authority to disseminate information to the public. The intent is not to prescribe how other agencies should notify the public but to strengthen a collaborative working relationship. The protocol could be included in an MOU or MOA with another agency or may be less formal.

2. Notification to the public of enforcement activities, which demonstrate consideration of cultural humility, literacy, or other special communication considerations.

The intent of this requirement is to demonstrate the health department’s implementation of protocols from Required Documentation 1.

Documentation of the process of notifying the public could be, for example, posting notices of enforcement actions to a website or social media, minutes of public meetings, press releases, etc.

Cultural, literacy, or other special considerations could include, for example, linguistic appropriateness, including both the language(s) used to communicate a message as well as tailoring messaging to address considerations such as literacy. Other methods could consider people with disabilities (e.g., using TTY/TDD technology or sign language interpreters). Other considerations could address cultural humility, which considers the approach for tailoring communication messages in the context of underlying values, perceptions, and beliefs that could influence understanding and behavior based on the information shared. The coversheet may be used to describe how consideration of cultural humility, literacy, or other special communication considerations were accomplished.

If another entity is responsible for enforcement, the health department could demonstrate sharing information with the public through, for example, web posts, social media, or other methods.

| Measure 6.1.7 A: Identify and implement improvement opportunities to increase compliance. |
| Purpose & Significance | The purpose of this measure is to assess the health department’s efforts to improve compliance by analyzing complaints, enforcement activities, and compliance rates; identifying improvement opportunities and implementing changes; and providing information to the public about the purpose of regulations. Understanding trends can help in employing preventive measures, pursuing opportunities for improvement in enforcement activities, and providing follow-up education. Assessing patterns and trends within the jurisdiction can lead to increased communication and foster collaboration with other enforcement agencies and partners to improve compliance. Another strategy for improving compliance is ensuring the public is aware of the purpose and value of public health regulations. |
| | Required Documentation | Guidance | Number of Examples | Dated Within |
| 1. Assessment of enforcement programs, which must include: | a. A summary of complaints, enforcement activities, and | The intent of this requirement is to show how the health department has assessed enforcement activities within the jurisdiction to identify opportunities for improvements that could foster increased awareness among the public, strengthen collaborative relationships or communication with other enforcement agencies, or | 2 examples | 5 years |
compliance.

b. Patterns or trends.

c. What worked well.

d. Problems that arose/issues identified.

e. Recommended changes in investigation/response, enforcement procedures, or other actions to improve compliance.

The examples must be from two different enforcement programs. If the department operates an enforcement program that is out of compliance with state law or is under sanctions or a performance improvement plan, then one of the examples must be from that program.

If the health department has no enforcement authority, this requirement does not apply.

For required element a:
The summary could be, for example, in a log, part of a larger report, included within an electronic system, etc. Complaints, enforcement activities, and compliance for each enforcement program may be within the same log or summary document or may be in separate logs or summary documents.

For required element b:
Patterns or trends may be related to the type of violation, enforcement actions taken, geographic location (e.g., accumulation of solid waste and related enforcement activities in one location), or other factors.

For required elements c-d:
The intent of these requirements is to evaluate the health department’s processes \(\text{not}\) that of the regulated entity, which could be related to the health department’s methods to provide education or enforcement to achieve compliance. The intent is \text{not}\ to show what worked well or was problematic for a single investigation, but instead to evaluate the enforcement program’s activities and processes, based on a review of its patterns/trends.

For required element e:
Changes or improvements related to internal processes could include, for example, improving efficiency by reassigning staff based on geographic patterns/trends (e.g., assigning staff and adjusting scheduling based on zip codes), or identifying a need for improved communication with regulated entities on how to achieve compliance based on repeated violations. Examples could also reveal opportunities to work with regulated entities in a culturally or linguistically appropriate manner, if violations are occurring based on barriers to understanding public health laws or regulations, etc.

2. Changes implemented to investigation procedures, enforcement procedures, or other actions to improve compliance.

If the health department has no enforcement authority the health department must provide a description of efforts taken to work with the entity with authority to promote compliance.

The intent of this requirement is to demonstrate improvements made to promote compliance. Improvement could be related to investigations, enforcement, or actions taken to prevent regulated entities from being out of compliance.

Examples could include, for example, revising the algorithm for inspections, launching an educational campaign among regulated entities based on a pattern of non-compliance issues, or providing information or training to improve compliance in a culturally and/or linguistically appropriate manner. Examples may demonstrate the recommended changes listed in Required Documentation 1 element e, above, or may relate to other implemented changes.
If the health department does **not** have enforcement authority, examples will demonstrate working with the entity with authority to improve as part of collaborative compliance. Health departments without enforcement authority could, for example, demonstrate working with the entity with authority to design educational materials or share information to improve compliance among regulated entities, or implement process improvements to coordinate and share information. Examples could include, for example, how the health department has learned from agencies that do have public health related enforcement authority about patterns or trends in order to strengthen partnership or collaboration to improve compliance (e.g., reports from or meetings with an environmental agency about patterns/trends in water quality managed by sewer or waste management). If the health department has **no** enforcement authority, efforts of the health department to engage with the entity with authority are required, **not** the successful implementation of changes.

### 3. Communication provided to the public on the purpose of public health regulations.

Examples must be from two different enforcement areas.

The intent of this requirement is that the health department demonstrate fostering awareness of the purpose or value of public health regulations to promote and protect health for the purpose of increasing compliance.

Communications with the public could be about, for example, tobacco-free ordinances, mandates, or the purpose of enforcement for restaurant inspections or public health nuisance regulations.

Health departments that do not have regulatory enforcement responsibility still have a responsibility to foster awareness and knowledge of laws that impact the public’s health. For example, the school system may have the responsibility to ensure that all children entering kindergarten have had age-appropriate vaccinations. The health department can provide education to the public on the purpose or importance of immunization laws.

The health department can also work with other partners (e.g., community-based organizations, other governmental agencies, policymakers, or governing entities) to produce the communication. In some instances, communications may have greater impact if they are disseminated by, or have the logo of, those other organizations. The health department can provide documentation produced by other organizations if it also submits an explanation in the coversheet of the health department’s role in helping develop the material.

**DOCUMENTATION EXAMPLES:**

Documentation could include, for example, a set of FAQs on the health department’s website, newsletters, training sessions, public meeting minutes, posters, press releases, or social media.
Domain 7
Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.

Standard 7.1
Engage with partners in the health care system to assess and improve health service availability.

Measure 7.1.1 A: Engage with health care delivery system partners to assess access to health care services.

Purpose & Significance
The purpose of this measure is to assess the health department’s participation in a collaborative process to develop an understanding of the population’s access to needed health care services, including behavioral health and primary care. Collaborative efforts are required to assess the health care needs of the population of the Tribe, state, or community. These data can be useful in developing strategies or seeking support to expand services.

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<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>1. A collaborative assessment of access to health care that includes the following:</td>
<td>The intent of this requirement is that the health department collaborate with health care, behavioral health, and others to assess the availability of health care services within the health department’s jurisdiction. The collaborative assessment addresses the availability of health care services for planning purposes. While the assessment will include behavioral health and primary care, it could also include other services (e.g., oral care, clinical preventive services, Emergency Medical Services (EMS), emergency departments, urgent care, occupational medicine, specialty ambulatory care, inpatient care, diabetic care, HIV health services, etc.). Multiple assessments may be provided to address the required elements, as needed.</td>
<td>1 collaborative assessment</td>
<td>5 years</td>
</tr>
<tr>
<td>a. A list of partners that were involved, which must include primary care and behavioral health providers.</td>
<td>For required element a: The health department could lead or be a member of the collaborative group, which may be comprised of community health assessment or improvement plan partners, or a separate collaborative. In addition to engaging members of the health care and behavioral health system(s), collaborative partners could include, for example, representatives of businesses or employers, health insurance companies, communities of color, Tribes, low-income workers, military installations, correctional agencies, specific populations who may lack health care and/or experience barriers to service (e.g., individuals with disabilities, non-English speaking, or other populations with special needs), social service organizations, or other stakeholders. For Tribal health departments it could include, for example,</td>
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<tr>
<td>b. Analysis of data on populations who lack access or experience barriers to care.</td>
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<tr>
<td>c. Analysis of data on the availability and gaps in services.</td>
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<tr>
<td>d. Conclusions drawn for reasons why patients experience barriers accessing care.</td>
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Indian Health Service, other Tribal programs and departments, and individuals representing communities that experience barriers to services (e.g., distance from service, transportation barriers).

For required element b:
Populations could be identified by a variety of characteristics that could include, for example, age (e.g., teenagers, older adults, etc.), ethnicity, geographic location, health insurance status, educational level obtained, intellectual or physical disabilities, discrimination (e.g., marriage inequality), or special health service needs (women who are pregnant, individuals with diabetes, etc.). Information could be obtained, for example, from surveys of particular population groups or secondary sources (e.g., emergency department admissions or population insurance status data).

For required element c:
Assessment of services could include, for example, the capacity and geographic distribution of providers (e.g., patient/provider ratios, those accepting new clients, etc.); or services that are not widely available (e.g., services with long wait times to get appointments or areas within the jurisdiction with limited or no providers).

For required element d:
Conclusions drawn based on the analysis of the availability and barriers could relate to the capacity and distribution of health care providers. For example, a lack of access to obstetric services may be caused by lower revenue/reimbursement rates forcing hospitals to limit or eliminate services. Other examples could include, for example, a lack of dental care providers or providers who will not accept certain types of payment (e.g., Medicaid or Medicare), or qualifying criteria that poses gaps in coverage for certain populations (e.g., those with pre-existing conditions).

Barriers could also include, for example, lack of insurance or underinsurance, lack of transportation to care/services, limited ability to speak or understand English, travel distance in rural areas, limited-service hours of health care, stigma associated with seeking behavioral health services, etc. The assessment could explore the root causes of those barriers, which may be related to social determinants of health, or aspects of social or environmental justice. For example, social and economic disadvantage, racism, under/unemployment, unsafe or insecure employment conditions, and social exclusion negatively influence health status and access to care. Barriers among specific populations could be caused by lack of trust in the health care system or providers leading to delayed routine medical services or screenings necessary to protect their health.

**DOCUMENTATION EXAMPLES:**
Documentation could be, for example, a report or excerpt of the community health assessment that specifically addresses access to care, or a separate assessment process that focuses on access to health care. The list of partners may be included in the assessment, in meeting minutes, etc.

### Measure 7.1.2 A: Implement and evaluate strategies to improve access to health care services.

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

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<th>Required Documentation</th>
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</table>
| 1. Collaborative implementation of strategies to assist the population in obtaining health care services. | The health department does **not** need to have convened or led the collaborative process, but it will have participated in the process to implement mechanisms or strategies. The collaboration could include, for example, working with community-based organizations, primary care providers, behavioral health providers, oral health providers, community health workers, or Community Health Representatives (CHRs), etc. In agencies with multiple divisions (e.g., superagency), the collaboration could be between public health and another division or department (e.g., public health and behavioral health). A one-time discussion would **not** meet the intent of the requirement, which is to show collaborative implementation. Examples could include documentation that indicate the health department’s role in the following:  
  - Building relationships with payers and healthcare providers, including the sharing of data across partners to foster health and well-being.  
  - Coordinating and integrating categorically funded behavioral and public health and primary care.  
  - Collaborating with organizations representing different cultural groups on a campaign to reduce stigma associated with seeking behavioral health services.  
  - Increasing the availability or methods to access timely, relevant, accurate care through telehealth services or other mechanisms.  
  - Arranging for transportation mechanisms or coordination of services, for example, for individuals who are home bound.  
  - Collaborating with partners on strategies to use community health workers, community health representatives, or patient navigators.  
  - Establishing a continuum of care model, for example, for substance abuse by working with behavioral health or first responders. | 2 examples | 5 years |
• Achieving policy changes or additional resources to facilitate access (e.g., Medicaid expansion programs or expansion of service availability among those eligible for Federally Qualified Health Center (FQHC) services).

Strategies may consider those who have barriers accessing care based on the assessment from Measure 7.1.1 (e.g., individuals who are older, have disabilities, or experience cultural, language, low literacy, or other barriers).

**DOCUMENTATION EXAMPLES:**
Documentation could be, for example, meeting minutes documenting strategies that have been implemented or an excerpt of a report or other document summarizing how strategies were implemented.

| 2. Evaluation findings of a strategy to increase access to health care, which must include collection of feedback from population(s) with lived experience related to barriers to care. The evaluation must relate to one of the examples in Required Documentation 1. | The intent of this requirement is that collection of feedback be gathered from those with lived experiences related to barriers to obtaining care or from patient populations of focus for the intervention. The health department may or may not be the entity to conduct the evaluation. If the evaluation is conducted by another entity, the feedback should still show gathering data directly from those individuals or populations, rather than their representatives or service providers.

Findings that summarize the results of the evaluation will be provided. The feedback collected from individuals is **not** required. The coversheet may be used to describe who participated in the evaluation.

The evaluation process may occur as part of the CHIP, or evaluation of health equity initiatives, or separate process. The evaluation may be a process evaluation (i.e., one that is seeking to improve the implementation of the initiative) or an impact evaluation (i.e., one that is seeking to understand whether the initiative met its goals).

In addition to collecting feedback from at least one un/underserved population about meeting their access to care needs, the evaluation could examine topics that include, for example, out-of-pocket or other cost reductions, timeliness or availability of appointments, increased service utilization, or ultimately improved health status or outcomes, etc.

**DOCUMENTATION EXAMPLES:**
Documentation could include, for example, an evaluation summary, report, meeting minutes, or a presentation showing evaluation findings about needed process changes or the impact of strategies on meeting intended goals. | 1 example | 5 years |
The purpose of this measure is to assess the state health department’s efforts to improve existing systems or create new systems that are designed to improve the availability of high-quality health care for all. State health departments play an important role in establishing and improving mechanisms and systems to ensure access to health care across local jurisdictional boundaries. State health departments should be knowledgeable about health care financing systems and other system-wide initiatives in order to champion policy changes that impact access to high-quality care.

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<tbody>
<tr>
<td>1. Efforts to develop or improve systems for ensuring the availability of health care. The documentation cannot be the same examples provided for Measure 7.1.2, but could demonstrate additional efforts to continue to improve systems or policies related to those examples previously provided.</td>
<td>The intent of this requirement is that the state health department demonstrates how it has engaged in efforts to change policies or systems in order to enhance availability of health care. The example could be of an effort that is still ongoing or did not meet the intended goals. While Measure 7.1.2 focuses on initiatives to increase access to care, this measure recognizes state health departments’ position in being able to influence state-level levers to ensure that systems are designed to make high-quality health care available to all. This may be through statewide initiatives related to, for example, financing, quality monitoring, delivery systems, or the healthcare workforce. State health departments could engage in these efforts collaboratively and do not need to be the lead in efforts provided as examples. Efforts could be demonstrated by working in collaboration with other parts of an umbrella agency, if, for example, the state office of human services, Medicaid or Medicare, is part of the same agency as the health department. Collaboration could also include, for example, state health insurance plans or health care financiers (e.g., Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs), Medicaid or Medicare, etc.). Efforts could include strategies, changes, or policies related to, for example, cost-sharing, reimbursement mechanisms to value outcomes (rather than volume), transparency on pricing or services covered under insurance, cost control strategies, mental health parity, reduction of waste and unnecessary costs through service efficiencies across providers, increased reimbursement for preventative care, all-payer claims databases or other data-sharing systems across sectors to facilitate information sharing and planning, coordinated service delivery (e.g., community health worker programming, medical homes, patient navigation systems, or integrated care models), quality monitoring or value-based payment, workforce development initiatives (e.g., tuition reimbursement or other efforts to incentivize care in underserved areas), or efforts to further health information exchange and interoperability.</td>
<td>1 example</td>
<td>5 years</td>
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DOCUlMENTATION EXAMPLES:
Documentation could include, for example, reports or other summaries of activities, meeting minutes showing activities, testimony, presentations, grant applications, or grant...
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

| 1. Multi-sector implementation of efforts to improve access to social services or to integrate social services and health care. |

Guidance

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 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.

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**Measure 7.2.2 A: Collaborate with other sectors to ensure access to care during service disruptions.**

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

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

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

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**Measure 8.1.1 T/L: Collaborate to promote the development of future public health workers.**

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

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

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<tr>
<td>1. Efforts to recruit a qualified</td>
<td>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</td>
<td>2 examples</td>
<td>5 years</td>
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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.

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.

<table>
<thead>
<tr>
<th>Standard 8.2</th>
<th>Build a competent public health workforce and leadership that practices cultural humility.</th>
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<tbody>
<tr>
<td>Measure 8.2.1 A: Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.</td>
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<tr>
<td><strong>Foundational Capability Measure</strong></td>
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<tr>
<td><strong>Purpose &amp; Significance</strong></td>
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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. |
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<tr>
<td>1. A health department-specific</td>
<td>The workforce development plan articulates specific objectives and strategies the health</td>
<td>1 plan</td>
<td>5 years</td>
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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 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:

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 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...
i. Measurable objectives.  
ii. Improvement strategies or activities with timeframes.

| 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. |
|---|---|
| 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, element d).

| 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 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... |
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 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.

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<tr>
<th>Required Documentation</th>
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<th>Number of Examples</th>
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<tbody>
<tr>
<td>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</td>
<td>The intent of this requirement is <strong>not</strong> to show performance reviews; rather, the intent is to show that professional development activities are identified and tailored towards meeting professional development needs. Those needs could be based on the position or the health department’s strategic workforce development needs (e.g., a professional development plan with learning or training opportunities for a staff member based on a promotion or new job duties or a professional development plan that includes an emphasis on equity consistent with the health department’s identification of that as a department-wide priority). In cases where a professional development plan is part of an employee’s performance review, the performance review section may be provided with personal information redacted. Professional development activities could include, for example, education assistance (e.g., time off for classes, tuition reimbursement, bringing classes to the health department), continuing education, training opportunities, mentoring, job shadowing, professional coaching, certification in public health, engagement in professional associations (e.g., serving on committees, reviewing conference abstracts), or opportunities to apply learned skills in their position. Topics could include, for example, conflict negotiation; customer service skills; community resilience; emergency response; presentation or public speaking skills; informatics or data visualization; 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. <strong>DOCUMENTATION EXAMPLES</strong> Documentation could include, for example, an excerpt from an employee’s annual goals or</td>
<td>2 examples</td>
<td>2 years</td>
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</table>
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.

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<tr>
<th>Measure 8.2.3 A: Build a supportive work environment.</th>
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<tr>
<td><strong>Purpose &amp; Significance</strong></td>
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<tr>
<td>The purpose of this measure is to assess the health department’s efforts to create an organizational culture and work environment that is supportive of the staff and to evaluate staff satisfaction. The work environment impacts job satisfaction, employee retention, and employee creativity and productivity. The work environment should support and foster each employee’s ability to contribute to the achievement of the department’s mission, goals, and objectives.</td>
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<th>Required Documentation</th>
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<td>1. A comprehensive policy or set of several policies that demonstrate a supportive work environment, which must address, at minimum, one provision of each of the following: a. Work-life balance.</td>
<td>The intent of this requirement is to provide policies that build a supportive work environment for staff that goes above and beyond state or federal laws. Documentation of examples affecting just one employee (e.g., a recognition of just one worker) would not be appropriate. For required element a: A work/life balance policy could include, for example, telecommuting, flexible schedules, allowing staff to bring children to work, or breastfeeding/lactation support, etc.</td>
<td>1 policy or set of policies</td>
<td>5 years</td>
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b. Employee recognition.
c. Employee wellness.
d. Inclusive culture.

For required element b:
An employee recognition policy could describe processes to recognize staff through, for example, a newsletter, employee of the month program, employee honor roll, recognition letter, or regularly organized recognition lunch, etc.

For required element c:
A policy could include, for example, health screenings and risk assessments, flu shots, exercise programs, nutrition information, stress reduction methods, employee assistance programs, tobacco/other substance use cessation programs, healthy food or physical activity policies or programs, or other efforts to create a culture of health and wellness. The policy could also address measures taken to support employees during public health emergencies to address the additional stress that can result from response. Documentation could be part of another plan or procedure (e.g., continuity of operations or surge plan).

For required element d:
Fostering an inclusive workforce could focus on building an authentic workplace which creates a welcoming and open-minded environment that nurtures individual expression of thoughts or feelings rather than conformity. A policy could include, for example, listing pronouns in email signatures, required unconscious bias training for all employees, acknowledging holidays of all cultures and providing employees the flexibility to use paid time off for those days, establishing an inclusion council or employee resource group, etc.

2. Assessment of staff satisfaction and actions taken, including:
   a. Systematically collecting feedback from staff.
   b. Drawing conclusions and making recommendations based on the analysis.
   c. Taking action based on the conclusions drawn from the staff satisfaction assessment.

The intent of this requirement is to collect feedback across the department and implement actions, which could be department-wide or related to sub-units.

Examples do not need to be extensive or costly. The assessment could be coupled with another assessment, such as a QI or workforce equity assessment.

For required element a:
Documentation of collecting feedback from staff could include, for example, spreadsheets of assessment data, or instruments such as forms, web surveys, or other methods. The assessment could be created and disseminated by the health department or by an outside organization (for example, the PH WINS survey). An employee suggestion box would not meet the intent of conducting an assessment. Evidence will demonstrate feedback on staff satisfaction was collected; individual responses are not required.

For required element b:
Examples of conclusions about feedback could include identification of themes in what the health department is doing well or opportunities for improvement based on data, and recommendations for acting on those findings. Documentation could include, for example, meeting minutes, summary report, etc.
For required element c:
Documentation of taking action could include, for example, meeting minutes of actions taken, completed QI project summaries to address opportunities for improvement, revised policies or procedures, evidence of staff events, evidence of new or revised communication methods from leadership, or evidence of other activities in response to the conclusions drawn based on the staff satisfaction assessment. The actions could focus on feedback collected from across the department or its sub-units or one particular topic or process, rather than overall satisfaction. If no opportunities are identified in element b, the health department could demonstrate expanding on strengths across the department (e.g., if the health department received positive feedback about some of the professional development or training opportunities that are available, it could seek to expand the number of employees who participate in those opportunities).

### Measure 8.2.4 S: Support efforts of Tribal and local health departments to strengthen the public health workforce.

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

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<tbody>
<tr>
<td>1. Support provided to Tribal or local health departments to be responsive to their needs regarding strengthening the workforce.</td>
<td>The intent of this requirement is that support is provided in order to bolster the workforce of Tribal and local health departments based on Tribal or local health department needs, rather than on a one time or one-way communication. A broad workforce development effort—for example, a collaboration with a school of public health to promote public health careers, in general—would not meet the intent of the measure, unless the example included coordination with one or more Tribal/local health department(s) or efforts to facilitate placements with Tribal/local health departments. Each example could support one Tribal/local health department (e.g., discussion with a particular health department) or could support multiple health departments (e.g., developing a leadership program open to health departments across the state or convening a group of health departments to work collectively on assessing and meeting workforce demands). 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. Support provided to Tribal or local health departments could include, for example:</td>
<td>2 examples</td>
<td>5 years</td>
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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.

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<tr>
<td>Funding to support workforce capacity building or educational/professional development activities or other resources (e.g., access to learning management systems).</td>
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<td>Collaborations formed with schools or programs of public health or other academic institutions to develop resources for use by Tribal and/or local health departments related to recruitment, retention, or succession planning.</td>
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<td>Conducting workforce assessments and using results for collective problem-solving to address gaps in workforce capacity or capabilities among Tribal and/or local health departments.</td>
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Documentation or the description in the coversheet will indicate how the support is responsive to Tribal or local health department needs. For example, the coversheet could describe how the results of an assessment were used to collectively problem-solve a gap or could describe a less formal approach of collaborative efforts to address needs.

The state may not be able to meet all requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful.
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.
      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.

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.

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 management 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 9.1.2 A: Implement the performance management system.

**Purpose & Significance**
The purpose of this measure is to assess the health department’s use of performance management practices in assessing performance and identifying and managing opportunities for improvement. A performance management system ensures that progress is being made toward department goals and allows the department to identify areas for quality improvement. Including customer feedback in the performance management system can amplify community voice and needs, especially among populations facing health disparities, higher health risks, or poorer health outcomes, which helps the health department focus on addressing the needs in the community.

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<th>Required Documentation</th>
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| 1. Implementation of the performance management system, which must include the following information for each of two performance goals:  
   a. Objectives with identified timeframes for measurement.  
   b. The data for each objective. At least one of the objectives must use customer feedback data.  
   c. Analysis of progress toward achieving objectives according to timeframes for measurement. | The intent of this requirement is to demonstrate implementation of the goals and objectives as defined in the performance management system.  
   For required element a:  
   Timeframes for measuring objectives (e.g., monthly, quarterly, etc.) are important because they establish a target date by which progress toward accomplishing goals will be assessed and can help the health department demonstrate accountability.  
   For required element b:  
   Data could be collected from secondary sources to which the health department has access or primary data collected by the health department. Examples of data include: 7 days to execute a contract or 57% of adults are vaccinated. | 2 examples | 5 years |
d. Next steps for the identified goals, based on the analysis of progress.

One example must be from a programmatic area and the other from an administrative area.

Customer feedback data could be collected from surveys, focus groups, interviews, or other methods to gather data. These data may be the same as or different from the examples required within 9.1.3 A. In the context of this requirement, “customer” refers to the group impacted by the performance management goal. In this sense, customers may refer to partners or key stakeholders or, if it’s an administrative goal, the customers may be internal to the health department.

For required element c:

Analyzing progress toward achieving objectives according to timeframes could include, for example, tracking or monitoring logs, performance management reports, dashboards, etc.

For required element d:

Next steps for the identified goals could include, for example, initiating a quality improvement project based on results, adjustment of targets based on actual performance results, or revised goals or indicators based on programmatic changes or changing priorities, etc.

Programmatic areas could include, for example, regulatory or enforcement actions (e.g., tracking whether restaurant inspections are completed according to mandated inspection schedules) or health education or promotion activities (e.g., reach of health education messages in the community).

Administrative areas could include, for example, contract management (e.g., tracking whether contracts are approved within an established timeframe), human resources functions (e.g., improving recruitment processes), staff professional development (e.g., effectiveness of the professional development process or whether staff are achieving professional development goals), workplace development (e.g., effectiveness of employee wellness program), or financial management system (e.g., process for tracking spend down).

**DOCUMENTATION EXAMPLES**

Formats for documentation could include, for example, dashboards with analytical notes indicating opportunities for improvement and next steps; performance management reports; monitoring logs or other statistical tracking forms demonstrating analysis or progress in achieving measures with notes indicating opportunities for improvement and next steps; or meeting minutes from the health department team responsible for monitoring the performance management system.

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**Measure 9.1.3 A: Implement a systematic process for assessing customer satisfaction with health department services.**

**Purpose & Significance**

The purpose of this measure is to assess the health department’s process for systematically collecting and using customer feedback to facilitate a customer focus and satisfaction with health department programs, services, and operations. Collection of customer feedback helps the health department to understand
performance in the eyes of those it serves and identify opportunities for the department to be responsive to their needs. Customer satisfaction processes involve standardized processes to collect, analyze, and draw conclusions that are used for future action. Taking steps based on that customer feedback is an important component of accountability and can help foster trust from the community.

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<tr>
<td>1. Feedback from external customers assessing customer satisfaction with health department services, which includes each of the following: a. Data collection efforts that facilitate feedback collection from individuals of varying languages or ability, or who are otherwise disproportionately affected. b. Analysis of external customer feedback. c. Conclusions drawn about that feedback.</td>
<td>The intent of this requirement is to collect feedback from individuals outside of the organization about their interactions with the health department. Employee satisfaction surveys or surveys of community members about health priorities would not meet the intent of this measure. Examples of processes that could be used to collect customer/stakeholder satisfaction could include, for example, forms, surveys, focus groups, or other methods. Customer groups could include, for example, vital statistics customers, food establishment operators, contractors, elected officials, partner organizations or agencies, etc. The health department could also collect satisfaction information from WIC clients or clinic patients about the process of seeking services at the health department. A survey focused only on the clinical (medical) care an individual received would be outside PHAB’s scope of authority. For required element a: Special efforts in the design of data collection could include, for example, alleviating language barriers through the use of interpreters, data collection instruments available in other languages, or considering individuals with disabilities. Efforts to facilitate data collection could also include, for example, addressing trust through the use of lay advocates or community representatives to foster open dialogue; or convening focus groups or town halls with special populations with efforts to alleviate barriers, such as transportation; or other efforts to alleviate barriers for special populations. Evidence will demonstrate feedback was collected (e.g., through a summary in the report or by providing the data collection instruments and an explanation of how they were used); individual responses are not required. The coversheet could explain how the effort facilitated data collection.</td>
<td>2 examples</td>
<td>5 years</td>
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<td>For required element b: Processes to analyze customer feedback could include, for example, spreadsheets of quantitative data and associated descriptive statistics; identification of common themes among focus group participants’ comments; or other quantitative, qualitative or mixed methods approaches to analysis. This analysis does not need to be complex but will demonstrate the health department analyzed the customer feedback data to determine performance related to customer satisfaction and quality of service. A print-out of raw data would not meet the intent of the measure. Documentation could include, for example, a report or presentation that includes a brief description of the analysis.</td>
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<td>For required element c:</td>
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Conclusions based on the analysis of feedback could include, for example, identification of themes or services the health department is doing well or opportunities for improvement. Documentation could include, for example, a report or presentation.

2. Actions taken based on the analysis and conclusions drawn from feedback from the customer groups documented in Required Documentation 1.

Examples of action taken based on customer feedback could include, for example, a quality improvement project, follow-up with staff or program areas identified in the feedback as having an opportunity for improvement, or a change in policy in response to conclusions from the examples in Required Documentation 1. In cases where feedback is positive and areas of improvement were not identified, the health department may show what actions were taken to continue the positive customer experience (e.g., applying similar approaches to other programs, making a purposeful effort to continue or expand on successful approaches, etc.).

**DOCUMENTATION EXAMPLES**

Documentation could include, for example, a report, meeting minutes, or other document that describes the action taken in response to the data analysis and conclusions drawn based on customer feedback.

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**Measure 9.1.4 A: Establish a process that guides health department quality improvement efforts across the department.**

**Purpose & Significance**

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

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**Required Documentation**

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<th>Guidance</th>
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| 1. A quality improvement (QI) plan that addresses each of the following:  
   a. List and description of key quality terms.  
   b. Key elements of the QI structure, which must minimally include a description of roles and responsibilities of those responsible for the QI plan’s implementation.  
   c. Description of QI learning opportunities offered to all levels of department staff.  
   d. Description of the process.  
   For required element a:  
   Inclusion of key quality improvement-related terms is intended to create a common vocabulary and clear, consistent message regarding quality improvement among staff, leaders, and other stakeholders.  
   For required element b:  
   In addition to roles and responsibilities of staff leaders and other stakeholders in the QI process, the description could include, for example, organization structure for the QI process; membership and rotation of QI council/team members; descriptions of staffing or administrative support for the process; or descriptions of specific budget or resource allocation for the department’s QI process.  
   For required element c:  
   Delivery methods for QI learning opportunities could include, for example, new employee orientation presentations, introductory online courses for all staff, more advanced trainings for lead QI staff, hands-on workshops, participation in learning communities, etc. QI. | 1 plan | 5 years |
for identifying, prioritizing, and initiating QI projects.

e. Goals and objectives with time-framed targets, and activities related to the department’s QI plan implementation.

f. Description of how implementation of the QI plan is monitored.

g. Communication strategies used to share with stakeholders about QI activities conducted by the health department.

learning opportunities could be integrated in the workforce development plan training list or schedule, which may be provided as a companion document.

For required element d:
The health department’s QI plan will include the steps for: identifying or collecting ideas for quality improvement projects (e.g., from the performance management system, customer feedback, staff suggestions, etc.); prioritizing ideas and selecting a QI project; and initiating a QI project for a prioritized idea. Health departments could consider how to ensure their methods for identifying potential QI projects are inclusive and open to the diverse perspectives of staff, partners, or community members. Prioritization processes could also include consideration about which projects would have the greatest impact on equity, because quality is defined by the communities served: there is no quality without equity.

For required element e:
The intent of this requirement is for the health department to establish goals and objectives with time-framed targets, and activities pertaining to implementation of the QI plan itself. Goals and objectives related to specific QI projects or listing of QI projects would not meet the intent of this requirement.

Goals and objectives could relate to, for example, quality improvement training or learning opportunities offered for staff; the number or type of quality improvement projects completed; the proportion of staff engaged in quality improvement plan activities; communication of quality improvement achievements or project outcomes to a variety of audiences; engagement of diverse teams in QI projects; consideration of equity impact in selecting QI projects, etc.

For required element f:
The intent of this requirement is to describe how the health department measures progress toward implementing the QI plan goals and objectives, as identified in required element e. Implementation of the QI plan could be monitored, for example, through the health department’s performance management system, by the QI Council/Team/Committee during their meetings, etc.

For required element g:
The QI plan will include a description of how the health department communicates its quality improvement-related efforts to stakeholders. Stakeholders could be internal or external to the health department.

Communications could be delivered through, for example, presentations with staff, members of the governing entity, or other health departments; quality improvement newsletters; public display of QI storyboards; staff meeting updates or presentations; QI Council/Team/Committee meetings; or other communications.
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.

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<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>1. Completion of quality improvement (QI) projects that demonstrate the following:</td>
<td>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.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
<tr>
<td>a. How the opportunity for improvement was identified.</td>
<td>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.</td>
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<tr>
<td>b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement.</td>
<td>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).</td>
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<tr>
<td>c. Use of a QI method.</td>
<td>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.</td>
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<tr>
<td>d. Use of QI tools to better understand or make decisions about:</td>
<td>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</td>
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<tr>
<td>i. The current process, effort, or gap.</td>
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<tr>
<td>ii. Root cause(s).</td>
<td></td>
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<td>iii. Possible solutions.</td>
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<tr>
<td>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 determine whether the project’s objective(s) was met and identify next steps resulting from the project.</td>
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One example must be from a program area and the other must be from an administrative area.

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<thead>
<tr>
<th>One example must be from a program area and the other must be from an administrative area.</th>
<th>One example must be from a program area and the other must be from an administrative area.</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
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</table>

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, flowcharting, 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.

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### Measure 9.1.6 A: Nurture a culture of quality by engaging staff at all organizational levels in performance management and quality improvement.

**Purpose & Significance**
The purpose of this measure is to assess engagement of leadership and staff in developing, using, assessing, and updating a performance management system and quality improvement. A culture of quality is nurtured when health department leadership and staff at all levels are engaged in a deliberate approach to continually assess and improve performance. Engagement across the department fosters awareness of the health department’s intended and desired future state to align the department’s units towards improving practices, processes, and interventions.

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<tr>
<th>Required Documentation</th>
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<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Findings from a performance management or quality improvement (QI) self-assessment.</td>
<td>The health department could develop its own performance management or quality improvement assessment or use existing models, for example, the Public Health Foundation’s Public Health Performance Management Self-Assessment Tool, self-assessment tools available through the Baldrige Performance Excellence Program, or NACCHO’s Roadmap to a Culture of Quality.</td>
<td>1 example</td>
<td>5 years</td>
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<td><strong>DOCUMENTATION EXAMPLES</strong></td>
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<td></td>
<td>Documentation could include, for example, results summarizing a performance management or quality improvement self-assessment, meeting minutes showing discussion of the results of a self-assessment, presentation, report, etc.</td>
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<tr>
<td>2. A functioning committee, team, or council responsible for:</td>
<td>The health department could have one team/committee/council focused on both performance management and QI or could have separate teams for each. These functions could also be the responsibility of another standing department committee, such as the management team or other internal team/committee/council.</td>
<td>1 or 2 committees, as needed</td>
<td>5 years</td>
</tr>
<tr>
<td>a. Implementing the department’s performance management system.</td>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Facilitating continuous QI.</td>
<td>Documentation could include, for example, a team charter, meeting minutes, an excerpt of the QI plan, or performance management reports produced by the team/committee/council.</td>
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<tr>
<td>3. Staff at all levels, including leadership/management staff, engaged in the health department’s performance</td>
<td>The intent of this requirement is that both leadership/management and non-managerial/frontline staff are engaged in the health department’s work related to the performance management system and QI. This intentional engagement of staff at all levels in decisions about the functionality and components of the performance management system</td>
<td>2 examples</td>
<td>3 years</td>
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</table>
management system or QI. The examples must include staff who are not in the committee/team/council described in Required Documentation 2.

- Fosters transparency and shared ownership among all staff. This could include, for example, engaging staff in developing and updating the list of performance goals and objectives. Similarly, involving staff in the development of the QI plan or in QI projects may help staff identify additional opportunities for improvement and may increase staff support for continuous quality improvement. The intent is that the health department engage staff beyond those who are already part of the committee/team/council (unless all health department staff are included in that council) in order to infuse quality improvement and performance management throughout the organization.

Tribal health departments can decide who to include from leadership. This could include, for example, the Health Department Director; a Tribal Council; a Tribal Health Advisory Board; an internal Division or other administrative unit within a Tribe; a Tribal Health Commission or Committee; a Tribal Health Board; or a Tribal Advisory Board of Commissioners.

4. Staff professional development completed in the area of performance management or QI.

- The intent of this requirement is to provide evidence that learning opportunities have been delivered to staff on QI or performance management. This could include, for example, the learning opportunities referenced in 9.1.4 or other opportunities related to QI or performance management. It could also include, for example, evidence of the health department's work with consultants or technical assistance providers to develop staff skills in these areas. Documentation will show both the content of the learning opportunity (e.g., training curricula and objectives, presentation, webinars, training materials, a description of the consultant's engagement or a learning community, etc.) and who on staff participated (e.g., attendance rosters or description of who attended training).

**Measure 9.1.7 S: Advance Tribal and local health department performance management systems or quality improvement.**

**Purpose & Significance**

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

**Required Documentation**

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<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Support provided to Tribal and local health departments to be responsive to their needs regarding performance management or quality improvement (QI). If Tribal health departments are located within the state health department.</td>
<td>The state health department will document that it has provided technical assistance and/or training in performance management or QI practices, methods, and/or tools to Tribal and local health departments. Support could be provided by coordinating performance management system or quality improvement trainings or webinars; creating communities of practice for sharing among practitioners; or providing resources, such as access to performance management system technology to support Tribal and local advances in performance management or QI.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>
The intent of this requirement is that support in performance management or QI is provided based on Tribal or local health department needs, rather than on a one time or one-way communication. This could include, for example, input on ways the state health department can ensure support is relevant to Tribal or local health departments could be gathered through meetings or surveys on performance management system development or implementation; QI activities or methods; or other related topics.

**DOCUMENTATION EXAMPLES:**

Documentation could include, for example, trainings, presentations, or minutes from community of practice meetings with a description of participants; or documentation (e.g., newsletters, briefing papers, e-newsletters, email notification) of exercises, tools, performance management systems or other resources provided to local and Tribal health departments. 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 suggestion made by a Tribal or local health department during a meeting.

The state may not be able to meet all requests. The aim is that state, Tribal, and local health departments are coordinating to ensure that the support that is provided will be useful.

### 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.

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<tbody>
<tr>
<td>1. Incorporation of research or practice-based information in the development of a new public health process, program, or intervention or revision to an</td>
<td>For required element a: The source of research or practice-based information could be formal, such as peer-reviewed journals, or informal, such as from a peer health department. Additional potential sources could include, for example, The Guide to Community Preventive Services, NACCHO Model Practices, &quot;What Works for Health,&quot; the Trust for America’s</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>
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.

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. As long as the research has been peer-reviewed or validated, the research could have been produced by health department staff, but it does not need to be.

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

### Required Documentation

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<tr>
<td>The intent of this requirement is to provide an example of an evaluation of how well a process, program, or intervention is being implemented (i.e., process evaluation) or if it is achieving its intended outcome (i.e., impact or outcome evaluation). While a formal evaluation is not required, the example will show how that quantitative or qualitative data were used to evaluate the program, process, or intervention. The health department does <strong>not</strong> need to be the entity that conducts the evaluation; documentation of an evaluation conducted on behalf of the organization would be sufficient. (In other words, the health department would document that they asked or contracted with another entity to conduct the evaluation or that they participated in the evaluation in some way, for example, by either helping to frame the design or reviewing the results.) The health department could also participate in a community-centered evaluation approach, in which community members are engaged in developing evaluation questions, collecting data, and interpreting and sharing results.</td>
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#### DOCUMENTATION EXAMPLES

Documentation could include, for example, an evaluation report or presentation, program or project report with evaluation findings submitted to a funding organization, or other summary evaluating a process, program, or intervention.

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<th>Number of Examples</th>
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<tbody>
<tr>
<td>1 example</td>
<td>5 years</td>
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### Measure 9.2.3 A: Communicate research findings, including public health implications.

#### Purpose & Significance

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

### Required Documentation

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<tbody>
<tr>
<td>The intent of this requirement is to show how the health department has taken research, assessed the findings for implications or impact on public health, and communicated those findings to stakeholders.</td>
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<th>Number of Examples</th>
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<tr>
<td>2 examples</td>
<td>5 years</td>
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</table>
a. The research must have been peer reviewed or validated by experts.  
b. The communication must include public health implications of the research.  
c. Examples must show how the research findings and implications were communicated outside of the health department.  

For required element a:  
Research is defined as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. Research in the context of this measure is characterized as being peer reviewed or validated by experts (validated means it was reviewed by an advisory board/expert review panel) to ensure accuracy and valid conclusions. This includes peer-reviewed articles or publications in research journals, which demonstrates credibility through a peer or panel reviewed source. Providing raw data, program reports, community health assessment, county health rankings, or other statistical or analytical reports that have not undergone an expert review process would not meet the intent of the measure.

For required element b:  
Documentation of the implications of research could include, for example, an explanation of how the research might influence public health interventions. This could be included in a presentation, prepared report, discussion at a meeting recorded in the minutes, web posting, email list-serve, newspaper article, webinar, or press release.

For required element c:  
Audiences could include, for example, the health department’s governing entity; elected/appointed officials; agencies, departments, or organizations that collaborate with the health department in the delivery of services; community and healthcare partners; and the general public. Audiences would be especially appropriate if involved in or affected by the research. Community Based Participatory Research is an example of an approach that could be used.

Measure 9.2.4 A: Foster innovation.

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

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<th>Required Documentation</th>
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<th>Number of Examples</th>
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<tbody>
<tr>
<td>1. Effort to foster innovation skills or practices/processes.</td>
<td>Public health innovation looks at and responds to unmet needs through the creation and implementation of a novel process, policy, product, program, or system. Public health innovation is intended to lead to improvements that impact health and equity. The intent of this requirement is to demonstrate one or more steps the health department has taken to encourage innovation. Steps could include, for example, offering trainings to staff on innovation; using approaches like design thinking to tackle problems; encouraging staff to develop prototypes to test new ideas; demonstrating leadership commitment to</td>
<td>1 example</td>
<td>5 years</td>
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creativity and an understanding that failure may be part of the innovation process; or collaborating with teams for co-production with people with lived experiences who will be affected by the results of the innovation. (See the Public Health National Center for Innovations, a division of PHAB, for additional examples of strategies to foster innovation.)

**DOCUMENTATION EXAMPLES**
Documentation could include, for example, training content, meeting minutes, project notes, policies or initiatives, etc.

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**Measure 9.2.5 T/S: Foster research.**

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

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<tbody>
<tr>
<td>1. Involvement with other researchers to foster research.</td>
<td>The intent of this requirement is that the Tribal or state health department be involved with other researchers (e.g., a practice-based research network; community based participatory research network; other states, Tribes, or local jurisdictions; educational or research institutions; etc.) to foster public health research. This could include, for example, the development, revision, or dissemination of a list of prioritized research topics/questions (i.e., a research agenda); providing mini grants to support students or researchers to conduct research on public health topics; or sponsoring or co-sponsoring a conference or other opportunities for researchers to present their findings. The intent of this requirement is to encourage the production of public health research. A collaboration with another institution on a single research study would not meet the intent of this measure. For Tribal health departments, this may include the incorporation of practice-based evidence grounded in cultural values, beliefs, and traditional practices. Tribal health departments may demonstrate participation in research conducted by larger Tribes, Tribal Epidemiology Center (TEC), the NIHB, and others who identify research needs and interests relative to improving the health of Americans Indians and Alaska Natives.</td>
<td>1 example</td>
<td>5 years</td>
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**DOCUMENTATION EXAMPLES**
Documentation could include, for example, a membership list or meeting attendance roster, meeting minutes, a research agenda (with an indication in the documentation or the coversheet about the health department’s involvement in its development), etc.

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**Measure 9.2.6 S: Provide support to Tribal and local health departments in applying relevant research results or evidence-/practice-based learnings.**
### Purpose & Significance

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

### Required Documentation

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<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Input gathered from Tribal or local health departments on their needs for support in interpreting, adapting, or applying relevant research results or evidence-/practice-based learnings. If Tribal health departments are located within the state health department’s jurisdiction, the example must reflect opportunities offered to all Tribes to provide their input on their needs.</td>
<td>The intent of this requirement is that state health departments have a process to understand what technical assistance, advice, direction, or guidance Tribal or local health departments would find relevant. Input on Tribal or local health departments’ support needs could be gathered through, for example, meetings or surveys on research topics or subject areas. One-way communication to Tribal or local health departments alone would not meet the intent of the measure which is to gather and assess support needs. The documentation will include an opportunity for the Tribal or local health departments to provide feedback. DOCUMENTATION EXAMPLES: Documentation could include, for example, evidence of a survey disseminated to Tribal or local health departments, meetings convened with feedback collected from Tribal or local health departments, etc.</td>
<td>1</td>
<td>5 years</td>
</tr>
<tr>
<td>2. Support provided to Tribal or local health departments to be responsive to their needs concerning the interpretation, adaptation, or application of relevant research or evidence-/practice-based learnings.</td>
<td>The intent of this requirement is to show how the state health department provided support to Tribal or local health departments in the interpretation, adaptation, or application of research or evidence-/practice-based learnings within their own jurisdiction. 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. Support could be provided by, for example, providing access to libraries of peer-reviewed research, providing access to journal articles, connecting Tribal/local health departments with research institutes or academic partners, etc. 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 support or indicate the types of support provided.</td>
<td>2</td>
<td>5 years</td>
</tr>
</tbody>
</table>
for assistance made by the Tribal or local health department on a phone call or through an email. This could be related to the activities described in Required Documentation 1, but it does not need to be.

Domain 10
Build and maintain a strong organizational infrastructure for public health.

Standard 10.1
Employ strategic planning skills.

Measure 10.1.1 A: Conduct a department-wide strategic planning process.

<table>
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<tbody>
<tr>
<td>1. A department-wide strategic plan process, which must include:</td>
<td>The planning process may have been facilitated by staff of the health department or by an outside consultant.</td>
<td>1 strategic planning process</td>
<td>5 years</td>
</tr>
<tr>
<td>a. A list of the individuals who participated in the strategic planning process. Participants must include various levels of staff and representative(s) of the health department’s governing entity.</td>
<td>For required element a: The health department’s size and organizational structure will define the various levels of staff engaged in the strategic planning process. The intent of this requirement is that both leadership/management and non-managerial/frontline staff contribute towards the strategic planning process. In a centralized system, the state health department will include staff serving local jurisdictions, as appropriate. Participation could include, for example, contributing towards an environmental scan (components listed within required element b) or developing elements of the strategic plan, such as, the mission, vision, values, or strategic priorities of the health department. Sharing a final version of the strategic plan would not demonstrate the intent of the measure. Similarly, presenting the final version to the governing entity for approval, would not meet the intent. While the health department need not engage the governing entity or staff in every strategic planning meeting, the intent is that at least one member from the governing entity or a liaison to the governing entity (e.g., a representative from the governor’s or mayor’s office) and staff provide input during the development process to inform the final version. The coversheet could be used to clarify participant titles and roles.</td>
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<tr>
<td>b. A summary or overview of the strategic planning process, which must include:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>i. The analysis of the department’s strengths and challenges.</td>
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</tbody>
</table>
### 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 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 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

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<tbody>
<tr>
<td>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. g. Linkage with performance management.</td>
<td>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 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</td>
<td>1 strategic plan</td>
<td>5 years</td>
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</tbody>
</table>
supplemented the plan to address required elements above.

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).

Measure 10.1.3 A: Monitor implementation of the department-wide strategic plan.

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

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

One example must demonstrate sharing with staff and one example must demonstrate sharing with the governing entity.

The intent of this requirement is that the health department informs the governing entity and both leadership/management and non-managerial/frontline staff on progress towards the implementation of the strategic plan. Regular communication fosters increased awareness of priorities and provides an opportunity for dialogue on the feasibility and effectiveness of goals and objectives as the plan is implemented.

In a centralized system, the state health department will include staff serving local jurisdictions, as appropriate.

**DOCUMENTATION EXAMPLES:**
Documentation could include, for example, meeting minutes, reports shared with the governing entity and staff, presentations, emails, or other discussion records.

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<th>Standard 10.2</th>
<th>Manage financial, information management, and human resources effectively.</th>
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<td><strong>Measure 10.2.1 A:</strong> Manage operational policies including those related to equity.</td>
<td></td>
</tr>
<tr>
<td><strong>Purpose &amp; Significance</strong></td>
<td>The purpose of this measure is to assess the health department’s process for reviewing, revising, and sharing health department policies and procedures with staff, as well as the incorporation of inclusion, diversity, equity, or anti-racism principles in department-wide policies or initiatives. Standardized policies and procedures ensure consistency across the health department’s operations to support the organization’s efficiency and effectiveness. Staff needs to have ready access to policies and procedures to be informed of organizational and operations expectations. Department-wide policies, declarations, or initiatives related to diversity, equity, or anti-racism principles can help infuse those concepts throughout the health department. An important first step in those initiatives is having a common understanding of the terminology related to equity.</td>
</tr>
<tr>
<td><strong>Required Documentation</strong></td>
<td><strong>Guidance</strong></td>
</tr>
<tr>
<td>1. Operational policies or procedures that are:</td>
<td>Operational policies are intended to direct the operations of the health department as a whole. Program policies would <strong>not</strong> meet the intent of this measure.</td>
</tr>
<tr>
<td>a. Reviewed and revised on a routine basis.</td>
<td>While HR/personnel and confidentiality policies could be contained within one comprehensive operational policy manual, these policies are specifically covered in other measures and would <strong>not</strong> meet the intent of this measure.</td>
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<tr>
<td>b. Accessible to staff.</td>
<td>Operational policies or procedures could address, for example, records retention and backup procedures; reimbursement; invoicing; emergency/evacuation procedures for the office; events planning; procurement of office supplies; facilities operations; use of department equipment (e.g., including phones and internet); use of department vehicles; in-office tobacco use; recycling; scheduling the use of meeting rooms; development of policies including who needs to sign what types of policies and how often they are reviewed (e.g., a</td>
</tr>
<tr>
<td>The examples must be for <strong>operational</strong> policies.</td>
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</table>
Health departments may use policies or procedures that are not specific to the health department, but are government-wide (i.e., Tribe, state, city, or county) or relate to a larger super-health agency or umbrella agency. These policies or procedures could demonstrate conformity with the measure if they apply to the health department’s operations.

For element a:
Official dates of policy or procedure revisions demonstrate that a review has been conducted within the last five years. This could be demonstrated by, for example, an operational policy or procedure with revised date, an email sent to staff with the revised policy or procedure, etc.

For element b:
Methods for staff access could be described in the coversheet or demonstrated through, for example, screenshots of a shared file folder or intranet page, emails to staff with the file location or revised policies or procedures attached, or photos of the location where staff can access hard copy versions. In a centralized system, the state health department will demonstrate operational policies that are applicable to staff serving local jurisdictions will be accessible to those staff.

### 2. Adopted definitions of equity terms.

The intent of this requirement is that the health department will determine what definitions it will use for terms related to inclusion, diversity, equity, or anti-racism in order to establish a common understanding among staff and set the context for department-wide efforts.

The health department will provide definitions of multiple equity-related terms, but the health department will determine which terms to define. Terms could include, for example, inclusion, diversity, equity, or anti-racism. The health department could use definitions established by others (e.g., definitions provided in the PHAB glossary, national or state organization, community coalition, etc.), or it could engage its staff in developing its own definitions that are relevant in the jurisdiction.

Documentation that terms have been adopted could include, for example, an excerpt from the strategic plan, memo, poster, or minutes from a staff meeting in which definitions were discussed and agreed upon.

### 3. Department-wide policy, declaration, or initiative that reflects specific intention with regard to inclusion, diversity, equity, or anti-racism.

The intent of this requirement is that the health department demonstrate how inclusion, diversity, equity, or anti-racism (IDEA) concepts are integrated throughout the department. Examples that are applicable only to a specific program in the department would not meet the intent.

Examples could address a department-wide policy about health equity as a guiding foundational principle or core value underlying all policies or operations; a description of an administrative initiative related to health equity (e.g., related to contracting, purchasing,
budgeting, communications, considering power in decision making); a policy about IDEA as a foundational principle underlying all policies; including IDEA as part of the health department’s mission, vision, and values; declaration of racism as a public health emergency; a department-wide focus on diversity and inclusion in recruiting participants in programs, advisory groups, and staff; etc.

While the definitions from Required Documentation 2 could be part of this example, the definitions alone would not meet the intent of this requirement.

### Measure 10.2.2 A: 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.

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<tbody>
<tr>
<td>1. A human resource manual or set of policies and procedures that address each of the following:</td>
<td>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.</td>
<td>1 set of HR policies</td>
<td>5 years</td>
</tr>
<tr>
<td>a. Personnel recruitment, selection, and appointment.</td>
<td>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)].</td>
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<tr>
<td>b. Equal opportunity employment.</td>
<td>For required element c: The requirement is referring to employee records (e.g., policy on confidentiality of employee records); it is <strong>not</strong> referring to expectations regarding HIPAA or protecting client health information.</td>
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<tr>
<td>c. Confidentiality of employee information and personnel records.</td>
<td>For required element f: Performance evaluation processes could include, for example, annual reviews, 360</td>
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<td>d. Salary structure.</td>
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<td>e. Benefits package.</td>
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<td>f. Performance evaluation process based on either job/position descriptions or annual objectives.</td>
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<td>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.</td>
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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.

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. |
| 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. |

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<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>1 process</td>
<td>5 years</td>
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</tbody>
</table>

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**

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<tbody>
<tr>
<td>1. An adopted, department-wide information security policy that includes the following:</td>
<td>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).</td>
<td>1 policy or set of policies</td>
<td>5 years</td>
</tr>
<tr>
<td>a. A description of the requirements for password complexity and lifespan.</td>
<td>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.</td>
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<tr>
<td>b. A process for ensuring physical security of information and network security.</td>
<td>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.</td>
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<tr>
<td>c. A policy for data that require additional privacy protection, which includes:</td>
<td>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.</td>
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<tr>
<td>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.</td>
<td>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</td>
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<tr>
<td>ii. A process for user access management for electronic data and data systems.</td>
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<tr>
<td>iii. A process for maintaining confidentiality of paper versions of those data.</td>
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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.

   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.
Initial Standards & Measures Version 2022
September 2021

| Measure 10.2.5 A: Ensure clean, safe, accessible, and secure facilities. |
| Purpose & Significance |
The purpose of this measure is to assess the health department's improvement of facilities for use by both staff and the public, as well as the accessibility of services held offsite. Facilities must be adequate in order for the health department to implement processes, programs, and interventions. All facilities that are operated by the health department must be clean, safe, accessible, and secure for both staff and the public. Improvements might be based on staff or customer complaints, or more formal assessments (e.g., OSHA, ADA, security assessments). |

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<tbody>
<tr>
<td>1. An improvement made to address the health department’s physical facility(ies) related to cleanliness, safety, accessibility, or security. Alternatively, the health department can provide assessment results demonstrating no physical facility improvements were needed.</td>
<td>The improvements could be demonstrated, for example, through completed work orders for facility improvements, or photos with a description of the work performed. Other examples of documentation could include, for example, environmental public health and safety committee meeting minutes and federal or Tribal environmental audits, or meeting minutes discussing and/or facility improvements.</td>
<td>1 example</td>
<td>5 years</td>
</tr>
<tr>
<td>2. Assurance of accessibility to health department’s facilities or services when services are provided offsite or temporary locations, based on Americans with Disabilities Act (ADA) requirements.</td>
<td></td>
<td>1 example</td>
<td>5 years</td>
</tr>
</tbody>
</table>
This measure does **not** address permanent health department facilities, which are already covered through the submission of ADA audits as part of the health department’s application. The intent is to demonstrate accessibility of temporary or intermittent offsite locations, which could include, for example, drive-thru medical services, pop-up tents, use of vacant parking lots (e.g., vaccine or supply distribution), community centers or schools (e.g., flu vaccine clinics), or community kitchen or garden (e.g., nutrition class).

Documentation could demonstrate actual or planned use of offsite or temporary locations considering accessibility, for example, by engaging the disability community (e.g., Centers for Independent Living, individuals with disabilities, or local organizations). Accessibility design aspects could consider, for example, wheelchair access, use of service animals, or appropriate signage for the deaf, blind, or hearing impaired, such as, use of braille, separate tactile or raised lettering, use of pictograms or visual aids, etc.

Documentation could include, for example, meeting minutes that include a discussion of accessibility when considering location; email chain with another location to ask accessibility questions; copy of the ADA compliance report of the facility, etc.

**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**

<table>
<thead>
<tr>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>

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.

**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
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.

<table>
<thead>
<tr>
<th>2 examples</th>
<th>5 years</th>
</tr>
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</table>

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 areas.

Each example must feature a written agreement with a different organization.

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.

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...
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.

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.
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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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</thead>
<tbody>
<tr>
<td>1. Quarterly (or monthly) financial reports.</td>
<td>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.</td>
<td>2 examples</td>
<td>2 years</td>
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<td></td>
<td>Financial reports for one program would not meet the intent of the requirement, which is to demonstrate financial reports for the entire department.</td>
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<td></td>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
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<tr>
<td></td>
<td>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.</td>
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<tr>
<td>2. External department-wide financial audit reports.</td>
<td>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.</td>
<td>2 examples</td>
<td>5 years</td>
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<tr>
<td></td>
<td>(two most recent audits)</td>
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<td></td>
<td><strong>DOCUMENTATION EXAMPLES</strong></td>
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<td></td>
<td>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.</td>
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<tr>
<td>3. Improvement steps identified based on findings from the most recent audit.</td>
<td>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.</td>
<td>1 example</td>
<td>3 years</td>
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<td></td>
<td>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.</td>
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</table>

Measure 10.2.8 A: Evaluate finances and seek needed resources to support ongoing and emergent needs.

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

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<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Financial analysis of available resources and financial support needed to maintain and improve public health infrastructure or services in the jurisdiction served by the health department.</td>
<td>The intent of this requirement is that the health department compare resources and expenditures (broken down by services or program/administrative areas) for the purpose of communicating the need for financial support for the health department. Typically, financial analysis is used to analyze whether the department is stable, solvent, and liquid. Financial analysis does not need to be complicated. Financial analysis of available resources could include analysis of revenue sources or look at historical data and projections for the future. Standard financial analysis could include, for example, cost benefit of expenditures, expenditure trend analysis, historical funding trends, cash flow analysis, forecasting, accounts receivable, and inventory depreciation. It could also include, for example, comparison of service specific or administrative-related resources and expenditures to other similar health departments by using the Uniform Chart of Accounts or other dashboard frameworks. Examples of analyzing those available resources related to the financial support needed could include, for example, analysis of allocations based on the health department’s strategic priorities, CHA/CHIP objectives, foundational public health services, prevention versus treatment programming, or other methods to evaluate returns on investment. The analysis could be created by the health department or by another branch of government (e.g., office of management and budget) as long as it is specific to public health infrastructure and services in the jurisdiction served by the health department.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
<tr>
<td>2. Formal efforts to seek additional financial resources or increase efficiencies. At least one example must show engagement with the governing entity.</td>
<td>The intent of this requirement is that the health department made a formal effort to seek additional financial resources or initiate a change to increase efficiencies. Additional funding to support public health processes, programs, interventions, and infrastructure could be sought through a variety of means, including budget increase requests, budget revision requests, and grants. Efforts could also address sustaining funding amid budget reductions (e.g., securing funding to supplement maternal or child health programs in the event funding is reduced). Other examples could include, for example, letters or testimony about financial support needs. The health department could also demonstrate ways to decrease inefficiencies and cut costs while still maintaining needed services for the community, for example, through shared service agreements. The examples do not have to have been successful. Engagement with the governing entity could include, for example, requesting funding from that entity; communicating to the governing entity about the need for additional financial resources or efforts to increase efficiencies; or having the governing entity, in conjunction with the health department, communicate with others about the need for additional financial resources for the health department.</td>
<td>2 examples</td>
<td>5 years</td>
</tr>
</tbody>
</table>
health department.

**DOCUMENTATION EXAMPLES**
Documentation could include, for example, grant applications (funded or unfunded); matching funds; requests to increase levies, taxes, or fees; or shared service agreements.

| 3. An example of flexible financial management during uncertain or unplanned events. | The intent of this requirement is to demonstrate how the health department has adapted its standard financial procedures to manage uncertain or unplanned events (e.g., disasters or unexpected increases or decreases in funding). Flexible financial management could ensure, for example, essential services will be resourced to sustain critical operations as identified in the COOP. Examples could include, for example, rapid program development and execution or program revision to address an unexpected event; the allocation of resources during an emergency to consider populations with higher health disparities and those disproportionately affected by unplanned events; or expedited written agreements with other entities. The example may show how the health department demonstrated flexibility in times of unexpected budget cuts or unanticipated increases in funding. | 1 example | 5 years |

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

**Measure 10.3.1 A: Deliberate and resolve ethical issues.**

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

<table>
<thead>
<tr>
<th>Required Documentation</th>
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<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>A procedure describing how public health ethical issues are deliberated and resolved.</td>
<td>For required element a: Having multiple individuals involved in the decision-making process allows diverse perspectives and expertise to deliberate about the ethical issue. The procedure could include, for example, how the decision-making panel for a given ethical issue is appointed (e.g., who makes the appointment, what factors are considered when appointing a panel for a particular issue) or what standing committee serves as an ethics panel (e.g., if the health department has designated an ethics board, or an existing committee—governing entity, executive leadership team, community council—to be responsible for the resolution of ethical issues). To foster accountability, health</td>
<td>1 procedure</td>
<td>5 years</td>
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<tr>
<td>b. How the decisionmakers gather information, including input from affected stakeholders.</td>
<td>departments may wish to be transparent about who participates in this decision-making process.</td>
<td></td>
<td></td>
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<tr>
<td>c. How the decision could be re-evaluated in light of new information.</td>
<td>For required element b: The procedure will describe the general process that will be used to gather information to aid in decision making. This will include, at minimum, gathering input from those who will be affected by the decision (e.g., to understand how they will be affected in the short and long-term, and to learn about their interests, perspectives, and concerns). It could also include how the decision makers will, for example, gather additional facts or relevant research (e.g., to understand the public health consequences of potential resolutions), learn about how other jurisdictions have addressed similar issues, determine if there is any precedent within the jurisdiction, etc.</td>
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<tr>
<td>d. How the decision is communicated back to affected stakeholders.</td>
<td>For required element c: Because ethical decisions are often made in the context of evolving situations (e.g., as additional research findings about diseases become available or as conditions in the environment change), it is important that the procedure have a policy for revisiting decisions based on new information. The procedure will describe the process for reconsidering and—if possible and appropriate—reversing the decision. This could include, for example, an opportunity for stakeholders to “appeal” a decision, a scheduled time for the decision makers to review decisions based on new evidence, etc.</td>
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2. Resolution or prevention of the occurrence of an ethical issue using the procedure provided in Required Documentation 1.

If an ethical issue has not occurred within the 5-year acceptable timeframe or since the deliberative process was adopted by the health department, an exercise using the deliberative process from Required Documentation 1 must be submitted as documentation for this requirement.

The example could demonstrate deliberation of ethical issues related to public health or general management ethical issues. Alternatively, the health department could demonstrate how it implemented the process from Required Documentation 1 to prevent the occurrence of an ethical issue from occurring; for example, considering the potential ethical implications or dilemmas faced related to vaccine roll-out and using a deliberative, collaborative process that includes input from stakeholders and the best available evidence to set the policy for how to conduct that roll-out.

Public health ethical considerations may require balancing restriction of individual freedoms or autonomy to protect the public good. For example, as part of communicable disease control (e.g., isolation and quarantine orders) there may be ethical considerations related to balancing an individual’s confidentiality protections while informing those who might have
been exposed to an infectious condition (e.g., contact tracing). Ethical issues might also relate to delivery of service considerations, for example, prioritizing populations in the allocation of scarce resources (e.g., vaccination or testing strategies). Other examples could address, for example, weighing the benefits and costs of changes to the public water supply or sewage system (e.g., shifting from privately constructed to public sewage systems).

General ethical issues could include, for example, the acceptance of gifts policies among employees, particularly those serving in a regulatory capacity (such as, food establishment inspectors offered free meals or beverages during inspections), unauthorized use of social media or balancing employee rights to express political or advocacy freedom within the workplace, etc.

**DOCUMENTATION EXAMPLES**

Documentation could include, for example, meeting minutes from an ethics committee or a report of the consideration and decision made pertaining to an ethical issue.

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**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.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
</table>
| 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. | 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. | 1 example per governing entity | 5 years |
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 implementation of the orientation process with the full governing entity(ies) as a refresher.

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.

**DOCUMENTATION EXAMPLES**

Documentation could include, for example, meeting minutes, PowerPoint presentation, or orientation materials.

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**Measure 10.3.3 A: Communicate with the governing entity routinely and on an as-needed basis.**

**Purpose & Significance**

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

**Required Documentation**

<table>
<thead>
<tr>
<th>Number of Examples</th>
<th>Dated Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 process description per governing entity</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**Guidance**

1. A description of the methods and frequency of regular communication with its governing entity(ies).

   Methods could include, for example, regularly scheduled meetings or correspondence, such as email updates, newsletters specific to the governing entity, or written materials. Frequency could be described, for example, within the governing entity’s charter or bylaws, legal requirements (e.g., ordinances may dictate the frequency of communication), orientation materials, etc.

   The health department may use the coversheet to indicate methods of communication (such as written correspondence) apart from meetings.

   If the health department has multiple governing entities, it must provide the process for each governing entity.

2. Communication about an emergent issue with the health department’s governing entity outside of its regular communications.

   The intent of this requirement is that communication with the governing entity be transparent and beyond the established frequency or traditional methods. Communications could include, for example, informing the governing entity about legislative or policy changes and their implication on public health practice or the health department, sharing information in rapid form during an emergency or emerging issue (e.g., changes in the availability of community resources, population health issues, etc.), or communicating for rapid decision making (e.g., key personnel or budget decisions). The communications could be initiated by either the health department or the governing entity.

   If the health department has multiple governing entities or entities serving in an advisory
capacity, the health department may select and provide documentation for this requirement based on any one of those entities.

### 3. Examples of sharing information discussed by the governing entity with all levels of health department staff.

The intent of this requirement is to foster awareness among all staff at all levels of the priorities, policy positions, opinions, and actions of the governing entity. Information flow about the governing entity’s discussions facilitates knowledge among staff of the important issues facing the health department and public health practice, as well as its future based on policies, decisions, or actions taken.

Staff at all levels will depend on the health department’s organizational structure, generally consisting of frontline (non-managerial/supervisory), mid-level, and/or leadership (managerial/supervisory) staff.

**DOCUMENTATION EXAMPLES:**
Documentation could include, for example, minutes from an all-staff meeting that included as an agenda item a summary of governing entity discussion; an email sent to staff describing governing entity discussions; or a notification to all staff about where they can find minutes from governing entity meetings on an intranet or website.

| Measure 10.3.4 A: 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). |

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<tr>
<th>Required Documentation</th>
<th>Guidance</th>
<th>Number of Examples</th>
<th>Dated Within</th>
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<tbody>
<tr>
<td>1. Engagement with legal counsel.</td>
<td>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.</td>
<td>1 example</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**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.