DRAFT FOR VETTING

***Reaccreditation* Standards & Measures Version 2022**

September 2021

Public Health Accreditation Board

Public Vetting Draft of Version 2022 Standards & Measures for Reaccreditation

September 2021

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

- Version 2022 for reaccreditation requires approximately the same number of documents as version 1.5, but does appear longer. Based on feedback from the field, the Standards & Measures include additional guidance and some of the longer measures have been divided.
- Based on feedback from the field, there is greater alignment between initial accreditation and reaccreditation. In some cases, the requirements are identical. You will see this indicated in the draft for reaccreditation (e.g., "Identical to Initial Measure 1.1.1").
- 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.
- 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 Reaccreditation. If you are looking for Initial Standards & Measures or Standards & Measures for Foundational Capabilities, see the Version 2022 webpage.

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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
Identical to Initial Measure 1.1.1.

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.

Requirements	Guidance	Document(s)	Dated Within
1. Community health assessment (CHA) that must include **all** of the following elements: a. A description of the collaborative process for developing the CHA. b. A list of participating partners involved in the CHA process. Participation must include: i. At least 2 organizations representing sectors other than public health. ii. At least 2 community members	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	1 community health assessment	5 years

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, 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	population served in order to inform the prioritization of policies, strategies, and interventions. As such, this process requires not only the collection but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders. The 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.		

must include assets or resources from sectors beyond healthcare and the health department.	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: Primary data are data for which collection is initiated or guided by the health department or CHA partnership. Data collection methods could include, for example, asset mapping, community/town forums, community listening sessions, surveys (such as surveys of high school students and/or parents), focus groups (such as sessions discussing community health issues), or other data that the health department/CHA partnership collects to better understand health challenges, contributing factors, or assets. Such information often provides additional context or details to help interpret secondary data sets. Non-traditional and non-narrative data collection techniques are acceptable forms of data collection. For example, an assessment could include photographs taken by members of the Tribe or community in an organized assessment process to identify environmental (including the built environment) health challenges (e.g., photovoice) or use of empathy mapping or ethnographic interviews to gather an understanding of current and historical inequities and their impact. Secondary data sources might include Federal, Tribal, state, and local data (not collected by, or on behalf of, the health department/CHA partnership). Specific secondary data sources could include, but are not limited to, Behavioral Risk Factor Surveillance Survey (BRFSS)/Youth Risk Behavior Surveillance (YRBSS) (if data collection is not initiated or guided by the health department or CHA partnership), County Health Rankings, CDC Disability and Health Data System, US Census American Factfinder, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, PH WINS, and/or Tribal Epidemiology Center data. Other secondary sources could include: vital statistics (if not collected by the health department); notifiable conditions data; clinical and administrative data collected by hospitals and/or health care providers, such as hospital discharge rates, insurance claims and Electronic Health Record (EHR) data; local and state chart of accounts; data from local schools, academic institutions, or other		

	departments of government (for example, recreation, public safety, etc.); community not-for-profits [for example, Aging and Disability Resource Centers (ADRCs)], 211 data, or other sources of nontraditional community; and environmental health indicators, such as housing, transportation, walkability/green space, agriculture, labor, and education. For required element d: In addition to ethnic and racial composition and languages spoken, demographic information could also include, for example, gender, age, socioeconomic factors, income, disabilities, mobility (travel time to work or to health care), educational attainment, home ownership, employment status, immigration status, sexual orientation, etc. For required element e: The intent of element e is to present a summary of themes and findings based on the data in element c, above. Disparities could include, for example, analysis of differences in rates of illness, death, chronic conditions, behaviors (e.g., smoking/vaping rates, high-risk sexual behavior), and other types of health outcomes in relationship to demographic factors (e.g., race, ethnicity, gender, sexual orientation, disability status or special health care needs, or geographic location). A table, or cross-tabulation, that demonstrates differences in chronic disease morbidity by race and ethnicity; or a map showing poorer health outcomes by zip code are some specific ways in which this could be presented. For required element f: Health equity relates to social justice in health; that is, everyone has a fair and just opportunity to be as healthy as possible. Examples could include, for example, a description of health inequalities based on differing availability of grocery stores in specific neighborhoods; differences in the built environment or walkability; differences in transportation routes as it relates to access to health care services in the jurisdiction. This analysis could also consider the disproportionate effects of climate change on subpopulations. As part of identifying factors that contribute to health challenges within the community, the description may also address related policies (e.g., taxation, education, transportation, insurance status, etc.) and consider the unique characteristics of the community that impact health status. Social determinants of health include factors in which people are born, live, and grow that influence health beyond a person's control, which **may** include		

	structural determinants or "root causes" of health inequities. Structural determinants include factors such as the political, economic, or social policies that affect income, education, or housing conditions. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual orientation, or other socially defined group of people. The description could include health equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes. For required element g: Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, etc. Intangible assets and resources could also be included, for example, community leadership, examples of social cohesion, and social capital. The collaborative partnership may determine that the community health assessment be updated on a different schedule, such as every 3 years. Dynamic community health assessments (i.e., websites that continuously update data content) are acceptable, if they contain elements a-g. A combination of webpage screenshots and other documentation and descriptions may be used to demonstrate the required elements. As dynamic community health assessments may be updated more frequently, a description of the method and frequency of updates can be provided to meet the timeframe requirement as long as the last updated date is within 5 years.		

Measure 1.1.2 A: Engage with partners across sectors and community members in the community health assessment process.

Purpose & Significance

The purpose of this measure is to assess how the Tribal, state, or community health assessment has evolved to deepen an understanding of the health issues facing the community by engaging partners from additional sectors and community members, as well as to assess how the community health assessment has been used to support efforts to improve population health. The partnership engaged in the assessment process will change over time to support the development of a thorough understanding of the health needs and assets throughout the jurisdiction. 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, program development, and development of funding applications.

Requirements	Guidance	Document(s)	Dated Within

1. Evolution of the community health assessment partnership's membership with a diversity, equity, inclusion lens.	The intent of this requirement is to describe efforts since the previous accreditation cycle to evolve the participation to reflect the partnership's growing understanding of the community. This could include, for example, adding new or different members to provide additional perspectives or to deploy tactics to more actively engage members. Health departments can consider a range of approaches in their efforts to intentionally lift up the voices of those that have been traditionally disenfranchised. New members can provide additional data sources, information, resources, and different perspectives to the community health assessment. Potential partnerships may be shaped based on health disparity data. For example, the CHA partnership may wish to obtain representation from community leaders or local or regional aging or disability agencies, or form/access Inclusive Health Coalitions which are composed of community members, self-advocates, families, community and/or faith leaders, and health care providers with disability health expertise, or others. It is not necessary to increase the total number of members, but to describe efforts to change the composition of the partnership to better represent or learn about the community. Efforts to increase participation could include, for example, providing stipends or addressing barriers to participation (i.e., lack of childcare), meeting in locations that are more accessible to community members. The narrative may describe efforts to evolve the partnership before or after the CHA was finalized.	1 example or a narrative of an example	5 years
2. Specific instance(s) of how the community health assessment was used by either the health department or partner(s). The description must go beyond how the health assessment was used in the development of the health improvement plan. While this may be included in the description, an additional instance(s) of use must also be described.	The community health assessment provides a foundation for efforts to improve the health of the population. In addition to being the basis for development of the health improvement plan, it can also be used, for example, as a basis for setting priorities, planning, program development, funding applications, policy changes, and coordination of community resources and collaborative use of assets, etc.	1 example or a narrative of an example	5 years

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

Measure 1.2.1 A: Collect and share public health data.

Foundational Capability Measure
Purpose & Significance: The purpose of this measure is to assess the health department's collection of primary data to create an increasingly robust, accurate, in-depth, and useful understanding of community health status, and to share data with health departments, organizations, and programs within the health department. The community health assessment is meant to be an evolving process that prompts the collection and analysis of new information. The community partnership continually increases its understanding of health issues and resources by asking additional questions and gathering additional data. 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. 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.

Requirements	Guidance	Document(s)	Dated Within
1. Primary data collected that demonstrate further exploration of issues initially identified in the community health assessment, including: a. One example of the health department's collection of primary quantitative data. b. One example of the health department's collection of primary qualitative data.	The intent of this measure is to document examples of primary data that have been collected to augment the community health assessment since it was initially adopted. The purpose of the additional data is to have a deeper understanding of the health issues and/or resources of the population or population group(s) that were identified in the community health assessment. Additional data could be specific to a particular neighborhood, population, health issue, age group, at risk group, or program area, for example. The collection of additional data need not be jurisdiction-wide but is meant to delve deeper into an issue to illuminate health inequities for increased understanding. Primary data could be collected by the health department or by other members of the community partnership, including, for example, Tribal Epidemiology Centers. Primary data could be collected through, for example, surveys of target groups, focus groups, key informant interviews, listening groups and other culturally appropriate methods, such as talking circles, Tribal consultation, etc. Primary data may be limited to a particular issue, population, or geographic area. Qualitative data could address, for example, the population's perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Data could be from, for example, key informant or group interviews, open-ended surveys, asset mapping, storytelling, focus groups, community or town forums, listening sessions, etc. Non-traditional and non-narrative data are acceptable. For example, the analysis could be based on an assessment that included photographs taken by members	2 examples or narratives of examples	2 years

	of the Tribe or community in an organized assessment process to identify environmental (including the built environment) health challenges (e.g., photovoice). Quantitative data may, for example, include close-ended survey data, vital statistics, or Behavioral Risk Factor Surveillance System (BRFSS) data if collected by the partnership. Documentation could be an addendum or an update to the CHA or a separate document with an explanation (in the coversheet, for example) about how additional data supplements the community health assessment. If the current CHA is less than 2 years old at the time of submission and the health department has not conducted additional data collection to further explore issues identified in the CHA, the health department may provide a previous CHA with examples of primary data that were collected to augment that CHA. If submitting a previous CHA, this should be explained on the coversheet.		
2. The process for receiving data requests and ensuring data are provided to each of the following: a. Other health departments. b. Other organizations. c. Other programs within the health department. The description must include how data are shared with Tribal health departments, if at least one exists in the jurisdiction. If there is not a Tribal health department in the jurisdiction, this should be indicated in the narrative or coversheet.	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 might 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). Health departments may share with a range of types of organizations including other health departments (e.g., a state health department sharing with local and Tribal health departments) and other entities (e.g., other governmental agencies, health care organizations, community-based organizations). In addition, health departments will more effectively serve their population if they have mechanisms in place to share data within the health department. For example, vital records data could be valuable for planning programs in chronic disease or maternal and child health. Methods for sharing data might include hard copy or electronic formats, such as, distribution through websites, information registries, data use agreements, or data distribution protocols.	Narrative description or policy/ procedure	Describe the current process(es)

Measure 1.2.2 S: Provide assistance to local and Tribal health departments regarding statewide data systems, data collection, and use.
Purpose & Significance The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in using statewide data systems and in other aspects of data collection and use. States maintain data systems (e.g., statewide registries, vital records systems) that are critical for capturing information about the health of the state. State health departments should 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 may be in a position to provide additional support to Tribal and local health departments to help bolster their capacity to collect and use data.

Requirements	**Guidance**	**Document(s)**	**Dated Within**
1. The process for helping local and Tribal health departments to collect and use data, which must include: a. How the state health department identifies what support local and Tribal health departments need to productively participate in statewide data systems. b. How the state health department is responsive to those needs. c. How local and Tribal health departments are able to access reports from statewide data systems. d. How the state health department provides additional support related to data collection and use. If there is not a Tribal health department in the state, this should be indicated in the coversheet.	State health departments play a critical role in ensuring Tribal and local health departments understand, have access to, and use data, including statewide data systems. For required element a: This would include efforts for the state, for example, to get feedback from local/Tribal health departments about technical assistance needs or system modifications that would make the system more usable; or to engage local/Tribal health departments in the development of new systems to ensure their feedback is reflected in requirements. For required element b: The health department could demonstrate it is being responsive to needs by describing how it provides technical assistance or support (e.g., support using or uploading data into statewide data sharing systems) that aligns with requests from element a. 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. For required element c: This could include, for example, how local and Tribal health departments are able to make requests for data or generate reports directly from the system. For required element d: In addition to describing the state health department's support for participation in statewide data systems, the process could also describe the state health department's support related to improving other aspects data collection, sharing, and use. For example, it could include technical assistance for	Narrative description of process	Describe the current process(es)

	administering surveys or focus groups, best practices in data sharing, access to analytical tools and training, or support related to making data available to the public. The support might also relate to use of data visualization tools, infographics, and dashboards, which can be powerful in benchmarking progress and facilitating communications with the public and/or private sectors, policy makers, and funders.		

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

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

Purpose & Significance
The purpose of this measure is to assess the health department's capacity to analyze data from multiple sources; to draw conclusions; and to share those findings. 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. 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.

Requirements	Guidance	Document(s)	Dated Within
1. Data from multiple sources analyzed with findings shared. At least some data must be specific to the population served by the health department or a subset of the jurisdiction's population. At least one of the examples must include both primary and secondary data. The analysis must include the analytic process used and findings. One example must demonstrate sharing analysis and findings externally, including with the health department's governing entity.	The purpose of this requirement is to assess the health department's capacity to analyze data from multiple sources and identify findings to understand health problems, assess behavioral risk factors, detect environmental public health hazards, or recognize social and economic conditions that affect the public's health. Analytic processes for quantitative data could include, for example, crosstabs, tests of significance (T-test, chi-square, ANOVA), or regression analysis. Analytic processes for qualitative data could include, for example, content analysis or thematic coding. Documentation could include, for example, data reports, presentations of data analysis findings, minutes of briefings, published articles, or other communication of the conclusions from data analysis. Evidence of the health department's analysis and findings 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.	2 examples or narratives of examples	5 years

Measure 1.3.2 A: Use data to recommend and inform public health policy, processes, programs, and/or interventions.

Required Documentation 2 is identical to Initial Measure 1.3.3
Purpose & Significance The purpose of this measure is to assess the health department's ability to analyze data to better understand a specific subpopulation and to use 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. To be able to target public health interventions where they can have the greatest impact, it is critical to analyze data about disparities in health status and inequities in the factors that contribute to health.

Requirements	Guidance	Document(s)	Dated Within
1. Analysis specific to a neighborhood, community, or population in order to understand health inequities or health disparities between specific populations and factors that cause or contribute to populations having higher health risks and poorer health outcomes. The analysis must include a description of the analytic process and findings.	The intent of this requirement is to demonstrate the analysis of data to understand health disparities and the factors that create or contribute to them. Qualitative data as well as quantitative data can be utilized. Data may be collected from primary or secondary sources. Geographic information analysis of socioeconomic conditions would be appropriate, for example. As part of addressing factors that contribute to health challenges of the community, analysis might also consider related policies (e.g., taxation, education, transportation, insurance status, etc.) and the unique characteristics of the community that impact health status. The analysis may be part of the Community Health Assessment, if the data are specific to a neighborhood, community or population; or the analysis can be contained in a separate report, memo, presentation, etc.	1 example or narrative of an example	5 years
2. Public health data analysis used to inform the development, revision, or expansion of policies, processes, 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.	The intent of this required documentation is to demonstrate how data analysis has been used. Data alone are **not** sufficient evidence for this required documentation. Policies, processes, programs, or interventions that affect health department employees only do **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.	2 examples or narratives of examples	5 years

	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.		

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 and improve 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 and for enhancing the surveillance system. 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)

Requirements	Guidance	Document(s)	Dated Within
1. A description of the surveillance system(s), which must address: a. The process to maintain the list of surveillance sites. b. A description of the health department's collaborative working relationship with reporting sites. c. How surveillance system data are used, including:	For required element a: Regularly updated and verified list(s) of surveillance sites supports surveillance efforts to know who reports conditions for rapid detection and encourages ongoing engagement to support collaboration during investigations. Surveillance sites could include, for example, health care providers, schools, laboratories, veterinarians, Tribal epidemiology centers, etc. The process for maintaining the surveillance site list could include, for example, reviewing the list for accuracy of current contact information or reporting methods. For required element b: Collaborative work with reporting sites could address, for example, training sites on notifiable/reportable or emerging conditions, reporting methods (e.g., clarifying what, how, and when to report notifiable or reportable conditions); communications with general	Narrative description	Describe current system

i. Analysis of surveillance data to identify patterns or trends. ii. Analysis of data to identify differences in population groups or root causes of disparities. d. Enhancements or significant changes made to the surveillance system. The health department must include how at least one of those changes was informed by data from the surveillance system. If surveillance 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, and analysis of surveillance data.	surveillance updates or disease/condition-specific requirements; or opportunities for surveillance sites to provide feedback to the health department about ways to improve the data reporting process. For required element c: The process for using surveillance data could include, for example, analysis of aggregated surveillance data to identify patterns or trends across the population served by the health department. Data may be disaggregated and further analyzed to identify differences in population groups across or by condition (infectious or non-infectious). For example, data on heart disease could be disaggregated by demographics, geographics, or other socioeconomic factors. Similarly, a health department could, for example, analyze immunization rates among school-aged children to identify sub-populations or groups requiring vaccination. Analysis might also consider analyzing inputs to consider root causes or contributing factors that influence health status. For example, environmental surveillance datasets could be analyzed to consider implications related to climate change or environmental justice. While the narrative description need not list every analysis conducted, the description will provide sufficient detail to describe generally how these data are used. For required element d: The intent is to describe how surveillance systems have been enhanced or key changes made since the health department's last round of accreditation (either initial or reaccreditation), which could include, for example, improving processes for surveillance sites to report more rapidly or accurately, expanding the number of surveillance systems used by the health department to include additional sources, improving existing systems (e.g. modernized systems for rapid detection, greater reporting or analysis capabilities, or interoperability with other systems) or significantly changing how staff use surveillance systems (e.g., using surveillance system data for geocoding or monitoring of additional factors, such as, socioeconomic, or social determinants of health, etc.). Enhancement efforts may be formal, such as a quality improvement project or may use less formal methods. Regardless of the methodology, the narrative will include at least one example of how data from the surveillance system were used to inform the change.		

Measure 2.1.2 A: Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental hazards. **Foundational Capability** *Identical to Initial Measure 2.1.3, Required Documentation 1 except reaccreditation adds access to laboratory.*
Purpose & Significance

The purpose of this measure is to assess the health department's ability to access 24/7 laboratory, epidemiological, and environmental health resources to rapidly detect, investigate, and contain/mitigate public health problems and environmental health hazards. Health departments must have access to these resources to facilitate prompt response to emerging health problems and hazards.

Requirements	Guidance	Document(s)	Dated Within
1. Policies and procedures outlining how the health department maintains 24/7 access to laboratory, epidemiological and environmental resources for the detection, investigation, and containment/mitigation for both public health problems and environmental public health hazards.	Policies and procedures may be contained in the Public Health Emergency Operations Plan or may be separate policies and procedures used by the health department, such as communicable disease policies and procedures or environmental health investigation and containment procedures. Resources may be within the department, such as in-house laboratory, environmentalists, sanitarians, and epidemiologists. If access to these resources is not available internally, the health department may have agreements with other agencies, individual contractors, or a combination in order to be responsive 24/7.	1 comprehensive policy and procedure or a set of policies and procedures	5 years

Measure 2.1.3 A: Improve and collaboratively implement practices for investigation, containment, and mitigation of health problems and environmental hazards. *Required Documentation 2 is identical to Initial Measure 2.1.6. Required Documentation 3 is the same as Required Documentation 2 in Initial Measure 2.1.5 except reaccreditation requires two examples.*
Purpose & Significance The purpose of this measure is to assess the health department's ability to conduct investigations and contain/mitigate public health problems and environmental health hazards, in collaboration with others. To advance health equity, containment/mitigation strategies require consideration of social determinants of health or health inequities. Coordinating with other organizations may support faster investigations or more effective mitigation. Partnerships may be particularly important when public health issues cross jurisdictional lines. In addition, working with community partners may help build trust and help reach more members in the community.

Requirements	Guidance	Document(s)	Dated Within
1. Updated practices for investigation or containment/mitigation based on lessons learned or surveillance data.	The intent of this requirement is to demonstrate that practices (which could include protocols or policies) are updated to guide future investigation or containment/mitigation practices. Investigation and containment/mitigation practices should be updated to reflect what the health department has learned based on, for example, investigations, containment/mitigation events, exercises, or new guidance or evidence. For example, health departments could update assignments of responsibility among staff, steps to conduct investigations, reporting processes, or contact management protocols. Examples	2 examples or narratives of examples	5 years

	could also address updates to the health department's protocols in working with others to conduct investigations or contain/mitigate health issues. Examples could also address updates to practices beyond protocols, such as changes to processes for exercising legal authority as part of advocacy or work with elected officials to address limited authority legislation.		
2. 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.	The intent is to work collaboratively on an investigation or mitigation, **not** 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. **DOCUMENTATION EXAMPLES** Documentation could include investigation reports and records, After Action Reports, meeting minutes, presentations, or news articles.	2 examples or narratives of examples	5 years
3. Efforts to address social determinants of health or health inequities incorporated into containment/mitigation strategies.	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).	2 examples or narratives of examples	5 years

	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 treatment, or receive emergency biologics or prophylaxis.		

Measure 2.1.4 S: Communicate about and support investigation at the Tribal or local level.
Identical to Initial Measure 2.1.8.

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.

Requirements	Guidance	Document(s)	Dated Within
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. 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.	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 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.	2 examples or narratives of examples	5 years
2. Support provided to be responsive to the needs of a Tribal or local health department when that Tribal or local health department was taking the lead on an investigation.	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.	2 examples or narratives of examples	5 years

If there were **not** two investigations led by a local or Tribal health department in the state during the 5 year time period, that must be indicated on the coversheet.	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. **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.		

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
Identical to Initial Measure 2.2.1.

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.

Requirements	Guidance	Document(s)	Dated Within
1. The public health emergency operations plan or the public health annex to its jurisdiction's emergency response plan. The submitted plan or	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	1 plan	3 years

annexes must include: a. A description of the purpose of the plan. b. The description of incident command system, including designation of staff responsibilities. c. The identification of the needs of at-risk individuals, which must include those with access and functional needs. d. At least two examples of processes to meet the needs of at-risk individuals (identified in element c). e. The lead role agency(ies), as well as the responsibilities of the health department specific to the following areas: i. Medical Countermeasures ii. Mass Care iii. Mass Fatality Management iv. Mental/Behavioral Health v. Non-Pharmaceutical Interventions, including legal authority to isolate, quarantine, and, as appropriate institute social distancing vi. Responder safety and health vii. Volunteer Management f. The process of declaring	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, 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:		

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. The EOP must cover the entire jurisdiction served by the health department or multiple EOPs must be provided.	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).		

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

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

Requirements	Guidance	Document(s)	Dated Within
1. Continuity of operations plan, which must include: a. Identification of essential public health functions that must be sustained during a continuity event. b. Orders of succession.	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.	1 plan	5 years

c. Identification of an alternate location for key health department staff to report, if necessary, or the ability to work virtually.	For required documentation 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.		
2. The process for expedited administrative procedures used during a response to an event that differ from standard procedures for **all** of the following: a. Accepting, allocating, and spending funds. b. Managing/hiring workforce. c. Contracting/procuring or mutual aid.	The intent of this requirement is to ensure the health department has an established process to access funding, workforce, and other forms of assistance in an expedited manner during an emergency. Documentation of one specific instance when a health department expedited a contract, for example, would **not** meet the intent of the measure. The process could take several forms, including, for example: • A separate formal policy (if, for example, the health department included administrative or finance teams in preparedness planning to develop a stand-alone plan to expedite administrative procedures); • Part of the Continuity of Operations Plan (COOP); or • Less formal documentation such as a presentation, memo between other governmental entities, etc. to describe the health department's process for how it works with other governmental entities (e.g., the state health department, budget office, county council) to expedite administrative procedures. For required element a: The process could address, for example, expedited acceptance of emergency preparedness funding for immediate use, such as, establishing an emergency fund, or financial approval	1 process	5 years

	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 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.
Required Documentation 2 & 3 are identical to Initial Measure 2.2.3 Required Documentation 3 & 4.

Purpose & Significance
The purpose of this measure is to assess how the health department has enhanced and improved its surge capacity and how it trains personnel engaged 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.

Requirements	Guidance	Document(s)	Dated Within
1. Significant changes and improvements made to the health department's surge capacity.	The intent is to describe improvements made to enhance the health department's surge capacity since accreditation, rather than a description of existing resources or processes for activation. For example, improvements could include adding new partners or modifying roles outlined in formal agreements (e.g., MOUs/MAAs/contracts) or resources, such as personnel, equipment, supplies, etc. Other examples could include improvements to identifying and engaging personnel or volunteers, such as the Medical Reserve Corp (MRC), based on role. The health department may have also expanded how personnel will fill roles beyond laboratory, epidemiological, and environmental personnel, (e.g., nurses, health educators, disease investigators, communications specialists or PIO support, logistics or information technology support, or administrative personnel). Improvements could also address, for example, how	Narrative description	5 years

	surge personnel will be notified/alerted or their roles and responsibilities in a surge when activated in relation to a given scenario.		
2. 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
3. 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 2), 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 why the proactive training was held. **DOCUMENTATION EXAMPLES:** Documentation could include, for example, training materials, recorded webinars, written training or deployment resources provided to responders, or written plans for how just-in-time training would be delivered.	1 example or a narrative of an example	5 years

Measure 2.2.4 A: Maintain a risk communication plan and a process for urgent 24/7 communications with response partners.
Foundational Capability Measure
Required Documentation 1 is identical to Initial Measure 2.2.4 Required Documentation 1; Required Documentation 2 is identical to Initial Measure 2.2.5 Required Documentation 1.

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

Requirements	Guidance	Document(s)	Dated Within
1. A risk communication plan that: a. Describes the process used to develop accurate and timely messages. b. Describes methods to communicate necessary information to the entire community, including at-risk subpopulations. c. Addresses misconceptions or misinformation. d. Describes the process to expedite approval of messages to the public during an emergency. e. Describes how information will be disseminated in the case of communication technology disruption. f. Describes the process for managing and responding to inquiries from the public during an emergency. g. Describes the process to coordinate the communications and development of messages among partners during an emergency. h. Contains a media contact list. i. Describes the procedure	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 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,	1 plan	5 years

for keeping the media contact list current and accurate.	individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals who have chronic medical disorders, or individuals who have pharmacological dependency, as well as transient populations, such as unhoused individuals or migrant farm workers. Individuals who do not trust the government or medical research due to a history of mistreatment might also be considered. For required element c: Addressing misconceptions or misinformation can help prevent public alarm. Methods could include, for example, proactively engaging with the public to correct misinformation, using technology or media platforms to share accurate information from reputable sources, or developing localized messaging in collaboration with community groups, members, or local organizations. Using multiple, credible sources is one way to help preserve the public's trust in public health findings and conclusions. For required element d: Expediting clearance methods could include, for example, establishing a process to clear information simultaneously (e.g., gathering subject matter experts, public information officers, and other decision-makers together at once to expedite the approval process), developing mechanisms to conduct a courtesy check with other response partners for message consistency, prioritizing messages on a "need to know" versus "want to know" basis, developing a strategy for message clearance that identifies key subject matter experts who are available to review messages for accuracy or policy advisor to ensure information is consistent with policies or laws, or developing a strategy to rapidly disseminate communication through web, social media, or media outlets. The approval process may also be part of the incident command system deployed in the community. For required element e: Methods in case of technology disruption could include, for example, radios or radio public service announcements, internet connections that use cellular data instead of wi-fi (e.g., air cards, tablets, cell phones), megaphones, door-to-door communication, or printed materials, etc. For required element f: Methods for managing and responding to inquiries from the public could include, for example, operating call centers, managing and responding to inquiries on social media or websites, or monitoring and responding to questions or topics raised by the public through the media, in person, or other channels. For required element g: Methods could include, for example, steps taken to ensure messaging with partners is		

	complementary and not contradictory, or a process to assess if communications are reaching intended target audiences. For required element h: The media contact list will include contact information. Restricted information may be redacted from the contact list. For required element i: The procedure could outline, for example, the frequency, staff member responsible, and elements of the media contact list reviewed and updated.		
2. An emergency communication protocol, process, or system for contacting response partners 24/7 during a public health emergency, which must include: a. A list of response partners that minimally includes health care providers, emergency management, emergency responders, and environmental health agencies. b. A description of how alerts are sent and received 24/7.	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 management, emergency responders (e.g., EMS, fire, police), pharmacies, mental health organizations, volunteer organizations, universities, the media, and neighboring health districts. Partners exist at the local, state, Tribal and federal levels. For required element b: If a series of screenshots are used to show the system, provide a description of how alerts are both sent and received on a 24/7 basis in the coversheet.	1 comprehensive or set of protocols or processes	5 years

Measure 2.2.5 A: Assess potential hazards, vulnerabilities, and resources in the jurisdiction.

Purpose & Significance
The purpose of this measure is to assess the health department's evaluation of potential hazards, vulnerabilities, and resources in a specific jurisdiction. The analysis assists preparedness planning by identifying potential targets that will likely impact a given community. (CDC, PHEP, ORR Interim Guidance, 2021)

Requirements	Guidance	Document(s)	Dated Within
1. Results of a risk assessment of potential hazards, vulnerabilities, and resources.	The intent of this measure is to provide the results of a risk assessment of potential hazards or threats (e.g., chemical/nuclear facilities, floods, extreme weather events), vulnerabilities (e.g., aging infrastructure, limited resources, human or community impact, etc.), and resources. A risk or hazard assessment can be used to inform strategies to meet the needs of vulnerable populations. The assessment assists preparedness planning by identifying vulnerabilities and prioritizing resources and programming should an emergency arise. The assessment does **not** need to be formal and could exist as part of a jurisdictional risk assessment (JRA), hazard analysis, or Threat Hazard Identification Risk Assessment, or standalone document. The health department does **not** need to lead the development of a risk assessment but could participate in another assessment conducted for the jurisdiction or region. **DOCUMENTATION EXAMPLES:** Documentation could be, for example, a hazard analysis, jurisdictional risk assessment, a memo, or a presentation or discussion during a meeting describing hazards, vulnerabilities and resources.	1 risk assessment	5 years

Measure 2.2.6 A: Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.
Foundational Capability Measure
Identical to Initial Measure 2.2.6.

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)

Requirements	Guidance	Document(s)	Dated Within
1. A plan for conducting response exercises, which indicates how	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	1 process	5 years

the elements in the EOP or annexes have been or will be tested.	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.		
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 agencies; non-governmental organizations (NGOs); 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.	2 AARs	5 years
3. Improvements based on AARs provided for 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, equipment; adoption of new technology, standards, or best practices; or the process for exercises, training, administrative planning, etc. The intent of this requirement is to show that a change has been made based on the AAR. It is **not** sufficient to provide an example of a planned changed.	2 examples or narratives of examples	5 years

	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.
Identical to Initial Measure 2.2.7.

Purpose & Significance
The purpose of this measure is to assess the **state health department's** support of Tribal and local health departments in the state in preparing for and responding to 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.

Requirements	Guidance	Document(s)	Dated Within
1. Support provided to Tribal or local health departments to be responsive to their needs in developing and testing emergency operations plans.	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.	2 examples or narratives of examples	5 years
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.	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.	1 example or a narrative of an example	5 years

If no emergencies have occurred within the last 5 years, documentation could be from a drill or exercise to test communications.	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.		

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
Required Documentation 1 & 2 are identical to Initial Measure 3.1.1 Required Documentation 1 & 2.

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

Required Documentation	Guidance	Number of Examples	Dated Within
1. Procedures for ongoing, non-emergency communications. The procedures must: a. Include the process for ensuring information is accurate and timely.	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	1 department-wide procedure or set of procedures	5 years

b. Describe the approach to tailoring communication to different audiences. c. Include the process for coordinating with community partners to promote the dissemination of unified public health messages. d. Describe the process to maintain a contact list of key stakeholders for communications. e. Identify which department staff position(s) is designated to perform the functions of a public information officer for regular communications. The procedure must define this position's responsibilities, which must include: i. Maintaining media relationships. ii. Creating appropriate, effective public health messages. iii. Managing other communications activities.	from that office to meet these requirements. For required element a: To ensure information is accurate, the procedure could, for example, include provisions for a review of communications by experts or a process for fact checking. Part of ensuring accuracy is making sure that the health department is not omitting data that provide important context and being transparent about how data may be updated or change over time. To ensure information is timely, the procedure could, for example, include guidance about target timeframes for responding to information requests or flow charts for content review with target timeframes. For required element b: Audiences within the community include subpopulations and at-risk individuals. Tailoring communications so they are appropriate for different audiences could include considerations of, for example, language, health literacy, or cultural humility. Cultural humility considers the way people view, experience and make choices about their health based on multiple factors, for example, religion, economic and educational factors, cultural value, beliefs, customs, and ways of living. Cultural humility involves a continual process of openness, awareness of biases, and life-long learning shaped by interactions with diverse individuals and populations. Health departments may consider how cultural, social and environmental factors affecting priority population(s) may influence their perceptions of communication efforts. For example, deeply rooted beliefs, including personal experiences, historical trauma, societal pressures or disenfranchisement may prohibit individuals from seeking health care or adopting changes in behavior. This process may also include consideration of unconscious/implicit bias (i.e., the underlying attitudes that people unconsciously attribute to another person or group of people that affect how they understand and engage with a person or group) in terms of information presented or omitted. Health departments may consider using asset-based language (i.e., language focused on the community's strengths, resources, and capabilities, rather than their problems and challenges) in their communications. For required element c: Partners might include community or volunteer organizations, governing entity, businesses and industries, academic institutions, or others including those who represent priority populations. The process could involve, for example, convening meetings with community partners to discuss methods of disseminating unified and		

	accurate information appropriate for the audience. For example, the process might include working with partners to develop coordinated press releases, public service announcements (PSAs), or joint web or social media campaigns. Taking an asset-based approach will focus on the context of which community partners are involved and what resources are available in the community to appropriately tailor communication for different audiences. For required element d: The process could involve, for example, the regular review and process steps to update contact information and ensure the list is current. Key stakeholders for communications could include, for example, the public information officers at other health departments (e.g., the state health department, neighboring local, Tribal, or military health departments) or other branches of government (e.g., county council, department of education, office of the governor) or communications staff at nonprofit organizations that can help expand the health department's communication reach (e.g., organizations whose constituents represent individuals with particular health concerns or subpopulations in the community). The media is a key stakeholder for communications; however, because the process for maintaining a media list is included in Measure 2.2.5 A, it is **not** required. For required element e: Documentation could be, for example, a job description or other description of responsibilities related to ongoing, non-emergency communications. The public information officer (PIO) function may be a dedicated position or performed by other staff; for example, the health director, deputy health director, or other staff assigned. The description should reflect the duties of the public information function regardless of the individual's job title. The PIO may be the same position during regular and emergency communications or may be different staff depending on the situation.		

2. Capacity to communicate with individuals who are: a. Non-English speaking, b. Deaf or hard of hearing, and 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.	1 example or a narrative of an example One example may reflect all required elements or evidence could be provided in multiple examples to cover all three required elements.	2 years or current agreement
3. A description of the health department's relationship with the media, which includes: a. What actions the health department has taken to proactively build relationships with specific media outlets. b. How the health department addresses media stories that include incomplete information or misinformation.	The intent of this requirement is to foster a positive relationship with the media. This may contribute to the media's understanding of public health and help ensure they cover important public health issues, which might include championing public health priorities for action. The media include print media, radio, television, web reporters, and diverse media outlets (for example, urban radio stations; free community newspapers; migrant worker newspapers; immigrant, ethnically targeted, and non-English language newspapers or radio stations, etc.) The health department's approach to develop ongoing relationships with media outlets could include, for example, ensuring the health department is familiar with which reporters are assigned the health "beat;" making health department staff or governing entity representatives available for interviews or quotes; providing editorials about public health issues, etc. The process for addressing incomplete or inaccurate information could include, for example, steps for monitoring news stories about public health, strategies for proactively reaching out to news media with potential corrections or additional context for news stories, etc.	Narrative description	Describe current relationship

Measure 3.1.2 A: Inform the public about public health's role, functions, and build a positive reputation of the health department in the community.

Required Documentation 1 is identical to Initial 3.1.2 Required Documentation 1.
Purpose & Significance The purpose of this measure is to assess the health department's strategy to communicate the value of public health with the aim of establishing a positive reputation in the community. To build effective public health programs and ensure sustained funding levels, it is important to foster greater understanding of what public health is and to convey the value, mission, roles, processes, programs, and interventions of the health department. Branding uses a common visual identity to effectively convey the presence, functions, and foster a positive reputation among community members.

Requirements	Guidance	Document (s)	Dated Within
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.	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 identify, 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. 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	1 policy, procedure, or set of policies or procedures	5 years

	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. The examples must address each of the following elements: a. Communicate what public health is, what the health department does, and why it matters. b. Integrate brand messaging into department communication strategies, as described in Required Documentation 1. c. Use a common visual identity (logo) to communicate the health department's brand, as described in Required Documentation 1.	The intent of this requirement is that the examples demonstrate implementation of the brand strategy, including how the brand strategy conveys the presence of the health department and value of public health, externally. For required element a: Informational materials, brochures, or website screenshots might discuss the role, contributions, and programs/services provided by the health department. Overview presentations about public health, its role, value, and services; or impact statements or annual reports could also demonstrate methods to communicate about public health. The intent is that the health department provide information about the importance of the health department and public health that fosters understanding about public health's contributions. Messaging about how the public is part of public health can help populations better understand the personal collective responsibilities of a healthy community. Information about a single health department program or service would **not** meet the intent. For required element b: Documentation could include, for example, branding integrated into screenshots of the health department's website, public service announcements, media releases, social media, etc. For required element c: Documentation should reflect actual use of the logo, for example, on a website, brochure, or other materials, rather than templates (e.g., blank letterhead).	2 examples or narratives of examples	5 years
3. A positive reputation fostered by the health department to build community trust.	The intent of this requirement is for the health department to show how it actively works to promote a positive reputation and trust among community members. The effectiveness of the	Narrative description	5 years

	health department's services and messaging requires building trust and a positive reputation among community members. Improving visibility and awareness of public health and the health department is part of fostering a positive reputation. This could include, for example, efforts to elevate awareness about health department activities in the community (e.g., by having employees wear clothing with the health department brand) or how the health department is an ally with other trusted community organizations. Other examples could include a periodic survey among community members to assess awareness and trust in the health department's services or functions. The intent is **not** to show customer satisfaction for a particular program or service; rather, the survey should relate to the health department as a whole.		

Measure 3.1.3 A: Use a variety of methods to make information available to the public and assess communication strategies.
Required Documentation 1 is identical to Initial Measure 3.1.4 Required Documentation 1.

Purpose & Significance
The purpose of this measure is to assess the health department's use, assessment, and enhancement of a variety of methods and formats to keep the public informed about the health department, public health and environmental public health issues, health status, public health laws, health programs, and other public health information. Health departments need to present public health information to different audiences through a variety of methods, including the use of social media. Health departments should assess their communications efforts to understand how well they are reaching community members and how they can be improved.

Requirements	Guidance	Document(s)	Dated Within
1. The health department's website or web page URL. The website will be assessed for the following elements: a. 24/7 contact number for reporting health emergencies. b. Notifiable/reportable conditions link or contact number. c. The jurisdiction's community health assessment and community health improvement plan. d. Public health data specific to the health department's jurisdiction. e. Links to public health-related laws or codes including enforcement related laws.	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. 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. 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. For required element d:	1 website	14 months

f. Links to permits/license applications. g. Information about and materials from public health program activities conducted by the department. h. Links to CDC and other public health-related federal, state, or local agencies, as appropriate. i. The names of the health department director and the department's leadership team. j. The address of the health department. k. A method for the public to submit comments to the health department. l. Evidence of at least one update to the website within the past 14 months.	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. 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. 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. 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. 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.		
2. Web and social media strategies enhanced to communicate with the public. At least one example must be based on an assessment of current communication strategies. One example must describe use of the health department's website or web page, the other example must address use of social media.	Describe how the health department's website and social media have advanced or evolved to provide strategic communications to the general public. For example, the health department may describe reorganizing website content to streamline navigation or expanding use of social media platforms. 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. To understand what communications strategies may benefit from enhancements and to plan those improvements, health departments may assess their current strategies. For example, the health department could assess its website analytics (reach, hits, etc.) or social media content (visits, new or total followers, impressions, shares, etc.).	2 examples or narratives of examples	3 years

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

Measure 3.2.1 A: Design and assess communication strategies to encourage actions to promote health. *Similar to Initial Measure 3.2.1, except reaccreditation adds element e.*
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).

Requirements	Guidance	Document(s)	Dated Within
1. A department-wide approach for developing and implementing communication strategies designed to encourage actions to promote health. The planned approach must include processes for: 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	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 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 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. For required element a:	Narrative description or 1 department-wide approach	5 years

of unified public health messages. e. Assessing how well the communication strategy is working.	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 the community or to tailor the dissemination based on community factors. In addition, if a health department is using an evidence-based practice, the health department can describe how it provides feedback back to the entity that sponsored the evidence-based practice about potential adaptations to make the intervention more appropriate in particular settings. Tribal health departments could include descriptions of talking circles, Tribal oversight committees, Tribal leader meeting, community meetings, Tribal consultation meetings, etc. For required element d: Consistency with the ongoing, non-emergency communications procedures, could include, for example, use of a checklist or standardized training materials with references to communications procedures or other standardized approach to follow procedures for providing accurate and timely information tailored for different audiences and coordinating with community partners. For required element e:		

	The intent of this requirement is that the health department describe the general approach it will use to assess whether communications strategies are achieving intended goals. Assessing the effectiveness of strategies may identify and lead to process changes in content, dissemination, or strategy. The approach to assessment could include, for example, feedback gathered from the target audience on the methods, frequency, and content of communication shared; analytics to determine communication reach; or ultimately, efforts to understand whether communications strategies were effective in achieving improved health outcomes or behavioral change. **DOCUMENTATION EXAMPLES** A planned approach could be described in a narrative or documented through, for example, a checklist, training module that includes these elements, policies and procedures, or other documentation that describes the factors to consider in developing and implementing health communication strategies and activities.		

Measure 3.2.2 A: Implement and evaluate health communication efforts to encourage actions to promote health.
Foundational Capability Measure

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

Requirements	Guidance	Document(s)	Dated Within
1. Communications campaigns implemented to provide accurate information to the public to address health risks, health behaviors, disease prevention, or wellness, which includes: a. A description of how community voice and public health research were incorporated to help shape the final content of information provided to the public. b. The final content that references an action that members of the public should	The intent of this measure is to demonstrate how the health department has implemented a campaign that uses multiple modes to communicate about the same public health issue. A communication effort that is only disseminated through one mode (for example, a public service announcement alone) would **not** meet the intent of this requirement. Public health information can address a broad range of public health promotion messages: • 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. Health information could address a combination of topics and messages. For example, unprotected sex, needle sharing, and HIV transmission could combine aspects of health risks, health behaviors, and prevention.	2 examples or narrative description of examples	5 years

take and describes why the action should be taken. c. A description of how the health department strived for cultural humility and linguistic appropriateness. d. Description of how the communications campaign information was shared or distributed through multiple modes. The examples must come from two different public health topics, one of which must address the prevention of a chronic disease.	Chronic disease program areas could include, for example, diabetes, obesity, heart disease, HIV, or cancer. For required element a: Public health research could 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. 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 would **not** be appropriate. Instead, the intent of this measures is to show how feedback is used to develop or revise messages/materials before they are delivered. A program evaluation would **not** meet the intent of this requirement. For required element b: The final content should convey action members of the public should take with a description of the reason(s). For example, a youth tobacco campaign might recommend teenagers avoid vaping or other tobacco products because of the associated health risks or might link to a resource for parents about how to talk with their teenage children. For required element c: Health promotion messages could, for example, be offered in multiple languages, include simplified wording and plain language, include visual aids for those of low literacy, consider health literacy, etc. Cultural humility considers the approach for tailoring communication messages in the context of underlying values, perceptions, and beliefs. National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare is a resource for these efforts. For required element d: To be considered a campaign, the same topic will have been addressed through multiple modes. For example, a campaign to encourage vaccination might include a combination of social media posts, public service announcements, and television and radio interviews. Distribution might also include public forums, health fairs or events, or presentations.		
2. Evaluation of communications strategies implemented. The evaluation must be one of the examples provided in Required Documentation 1.	The evaluation does **not** need to be complex or costly (i.e., the health department need not contract with an external marketing or communications vendor). The health department could evaluate, for example, the degree to which the selected evidence-based or promising practices were appropriately tailored to meet community needs; whether other practices might have been used to elevate community voice; whether the	1 example or a narrative of an example	5 years

	message was communicated in a culturally and linguistically appropriate manner. The evaluation might also include consideration of communication methods or modes (e.g., was social media or the website the best vehicle to reach target audiences or could methods be more effective, perhaps by examining website or social media analytics to determine reach and engagement). **DOCUMENATION EXAMPLES:** Documentation could be, for example, meeting minutes showing discussion of evaluation findings among staff, a presentation, or report.		

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: Foster cross-sector collaboration to advance equity.
Foundational Capability Measure

Purpose & Significance
The purpose of this measure is to assess the health department's general approach to collaborating with other sectors, as well as its engagement in cross-sector collaborations to advance equity. Coalitions provide the opportunity to leverage resources, incorporate various perspectives and expertise, coordinate activities, and employ community assets in new and effective ways. Coalitions include engagement with community members so that they are involved in the process and participate in the decisions made and actions taken.

Requirements	Guidance	Document(s)	Dated Within
1. Approach to cross-sector collaboration or alignment. The narrative must describe: a. How the health department has fostered a culture of trust with other sectors. b. How the health department has fostered inclusiveness with sectors and organizations or community members that represent historically excluded populations.	Addressing complex and evolving community factors that influence health involves cross-sector collaborations aligned towards achieving shared goals. Cross-sector collaborations demonstrate a commitment to community, require trust and humility, and establish a space for collaboration. They can spur innovation as they require strategic engagement that touches on multiple social and structural determinants of health and requires partners to come together and be creative in addressing issues collectively. Cross-sector collaboration and alignment involves working towards a shared vision or common goal, communicating consistently and transparently, sharing	Narrative description	Describe the current process or steps

c. How the health department has encouraged the use of a process(es) or framework(s) that advance equity. Specific process steps or framework must be described.	data towards achieving indicators or outcomes, and leveraging resources to sustain progress. Partnerships that work toward advancing equity and transforming how a community works together will include a broad, diverse array of cross-sector partners that include the community, sectors that represent historically excluded and marginalized populations, and traditional partners (e.g., local government, not-for profits, for-profits, community organizations, health care, etc.). For required element a: Fostering a culture of trust requires open communication. Trust takes time to establish and benefits from consistent commitment. The description could include, for example, how the health department engages in active listening, how they ensure resources are available (including adequate staff time) to build relationships, or how they have sought to be allies or participate in alliances to demonstrate their genuine interest in working collaboratively towards a shared purpose. For required element b: The description could include how the health department seeks out sectors, organizations, or community members that have not historically engaged with the health department or who have been marginalized. It could also describe the steps taken to create an inclusive environment. This might include engaging in collaborative decision making or using power mapping as a visual tool to identify additional sectors or partners to promote change. For required element c: Frameworks with resources to support cross-sector collaboration include the Framework for Aligning Sectors of the Robert Wood Johnson Foundation; Communities in Action: Pathways to Health Equity; Collective Impact; or Bay Area Regional Health Inequities Initiative (BARHII); etc. The narrative might address the approach the health department has used in various collaborations, whether the health department has convened them or actively participated in them.		
2. Cross-sector collaboration that advances equity or health equity. The example must include:	For required element a: Describe how a collaboration with other sectors developed a mutual understanding or shared purpose, which could be based on a significant challenge (e.g., cost, efficiency, inequities, etc.), a philosophical or historical injustice (e.g., service to a vulnerable population, etc.), or external or internal nudge (e.g., community input, political or funding expectations, etc.). The	1 example or a narrative of an example	5 years

a. A shared purpose and priorities. At least one priority must relate to equity or health equity. b. A participant list, which must include health sector, non-health sector, and community members. At least one organization or community member must represent historically excluded populations. c. A description of how data are shared. d. A description of the decision-making process, including how the community is involved in decision making. e. A common way of assessing progress towards outcomes. f. A description of how expertise, assets, or resources from the collaboration were accessed and coordinated. g. Efforts to explore sustainable funding.	shared purpose should reflect the intended purpose of what the collaboration with other sectors aims to achieve. For required element b: Various sectors could include, for example, local government (e.g., elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.), for-profits (e.g., businesses, industries, and major employers in the community), not-for profits (e.g., chamber of commerce, civic groups, local Childhood and Women's Death Review organizations, public health institutes, environmental public health groups, groups that represent minority health, etc.), community foundations and philanthropists, voluntary organizations, health care providers (including hospitals), entities that represent historically excluded populations (for example, minority-owned business, community-based organizations [CBOs], Black-led media, non-dominant religious groups, etc.), academia, or other health departments (state, local, Tribal, or military). 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 **<u>not</u>** meet the intent of including community members. For required element d: The decision-making process could include, for example, the governance infrastructure of collaboration, such as leadership of a multisector steering committee or oversight committee, with defined roles and relationships across the collaboration. The description could also explain processes that allow for participation by all parties in making decisions and community input, such as holding public forums or open meetings; or having transparent, deliberative processes for determining how the perspectives of partners and engaged community members are honored and included in decision-making. For required element e: Using a common strategy for assessing progress will reinforce having a mutual understanding of the shared purpose. Progress could assess improving health outcomes or outcomes related to, for example, strengthening social engagement, increasing social capital, strengthening trust, increasing shared accountability, or improving community resilience.		

	For required element f: Community assets include individuals, citizen associations, local institutions, political leaders, businesses and industries, nonprofits, faith-based organizations, informal community leaders, government agencies, voluntary organizations, community foundations, arts and cultural organizations, etc. Community mobilization and coordination involves organizing community assets to increase community control and political efficacy for improved quality of community life, community resilience, and health equity. For required element g: Describe strategies for collaboratively seeking sustainable funding, which could include, for example, working together to identify and leverage community resources and assets (e.g., both tangible resources like the built environment and intangible ones related to social capital and civic engagement), using innovative financial models that including blending and braiding funding (e.g., establishing local wellness funds), etc. Having mechanisms to hold the collaboration accountable for how they use those resources is also an important step to building trust.		

Measure 4.1.2 A: Engage with the community to address public health issues and concerns.
Similar to Initial Measure 4.1.3 except reaccreditation adds use of a model framework.

Purpose & Significance
The purpose of this measure is to assess the health department's approach to, and implementation of, authentic engagement with community members to address public health issues and concerns. Community engagement is an ongoing process of dialogue and discussion, collective decisions, and shared ownership. Public health improvement requires social change; social change takes place when the population affected by the problem is involved in the solution. Community engagement also has benefits of strengthening social engagement, building social capital, establishing trust, ensuring accountability, and building community resilience.

Requirements	Guidance	Document(s)	Dated Within
1. Strategies implemented to promote active participation or eliminate barriers to participation among community members, consistent with an adopted framework.	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. The narrative, example, or coversheet will reference the framework used by the health department. Community engagement models or frameworks include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), and Community-Based Participatory Research (CBPR). These models are used to determine areas of need,	1 example or a narrative of an example	5 years

	level of engagement, range of collaboration, or willingness and readiness of the community to engage and maintain health behaviors. 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 be, 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.		

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

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

Measure 5.1.1 A: Examine and contribute to improving policies and laws. **Foundational Capability Measure** *Identical to Initial Measure 5.1.2.*
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.

Requirements	Guidance	Document(s)	Dated Within
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).	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 **not** meet the intent of this measure. Documentation can address policies either in effect or proposed and can address policies at the local, Tribal, state, or federal level. Reviews could be of a policy that the health department enforces (e.g., laws related to indoor smoking or to the issuance of quarantine orders) or of a law that the health department has no legal authority to enforce, but that has implications for the health of the public in the jurisdiction of the health department. Policies or laws that others enforce but impact public health could include, for example, helmet use laws, school nutrition requirements, sale of tobacco products to minors, animal rabies vaccination laws, school requirements for proof of childhood vaccinations, or regulations to reduce carbon use or pollutants. The review of the policy or law could include a cost-analysis, which may be conducted by the health department or by another entity. Health departments could consider engaging legal counsel in the review of policies of laws. Sharing with those who set policies or stakeholders that influence policy could be demonstrated through, for example, the distribution of materials, presentations, or official testimony. It is **not** necessary for the health department to share the entire review with those who set policy. The health department could, for example, share an executive summary or a brief memo highlighting key findings for policy makers. Those who set or influence policy could include, for example, governing entities; local, state, or federal legislative bodies; local boards of education, transportation, etc.; Tribal District Chairpersons; elected	2 examples or narratives of examples	5 years

Documentation includes both the findings from the review **<u>and</u>** how they were shared.	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: Adopt a community health improvement plan.
Foundational Capability Measure
Identical to Initial Measure 5.2.2.

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.

Requirements	Guidance	Document(s)	Dated Within
1. A community health improvement plan, which includes all of the	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.	1 plan	5 years

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	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 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.		

the status of the effort or results of the actions taken to implement CHIP strategies.			

Measure 5.2.2 A: Encourage and participate in collaborative implementation and revision of the community health improvement plan.

Purpose & Significance

The purpose of this measure is to assess the health department's efforts to ensure that the strategies of the community health improvement plan are implemented, assessed, and revised as indicated by those assessments. Any plan is useful only when it is implemented and provides guidance for activities and resource allocation. Effective community health improvement plans should not be stagnant, but dynamic to reflect the evolving needs of the population served. Health departments should continuously work with multi-sector partnerships to evaluate and improve the community health improvement plan. While goals, objectives, and priorities are meant to be long range, strategies may need to be adjusted.

Requirements	Guidance	Document(s)	Dated Within
1. A story of implementing a CHIP strategy or initiative. The example must describe (either in the narrative or the coversheet of an example) the health department's role in the implementation and which CHIP priority the example addresses. If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP. (Documentation must demonstrate the linkage between the activity/strategy and the prior CHIP. Although the prior CHIP may be more than 5 years old the	The story could describe successes or unsuccessful implementation, including what was learned based on the implementation of a specific community health improvement strategy or initiative as a narrative or documentation of an example. If provided as documentation, the example could include, for example, a news article, meeting materials, excerpt of an annual report, a grant that was received, or presentation demonstrating how the strategy or initiative was implemented. Describing the impact of that initiative on health or health equity may help the CHIP partnership demonstrate the value of population health interventions.	1 example or a narrative of an example	5 years

implementation must have occurred within 5 years.)			
2. The collaborative process to review and revise the community health improvement plan.	The intent of this requirement is to show how the community health improvement process evolved and matured. The narrative could address, for example, the process for reassessing and revising community priorities, considering new or additional information or data, the availability of resources, health needs, or latest community health assessment findings. Other examples could be related to the process to update the plan, for example, how strategies are revised based on a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. The revision process may consider the improvement strategies, planned activities, time-frames, targets, or assigned responsibilities listed in the plan. Changes may also be related to the partnership itself, such as changes to how the collaborative or partnership is structured or governed, or how community members are engaged in decision making and co-creating solutions, etc.	Narrative description	Describe current process
3. Community health improvement strategy or initiative that was revised. If the plan was adopted less than a year before it was submitted to PHAB, the health department may provide implementation from an earlier CHIP. (Documentation must demonstrate the linkage between the activity/strategy and the prior CHIP. Although the prior CHIP may be more than 5 years old the implementation must have occurred within 5 years.)	The intent of this requirement is to demonstrate how the CHIP is a living document that continues to evolve after it is released. An example about how strategy or initiative from one cycle of the CHIP was improved in the second cycle would **not** meet the intent of the measure.	1 example or a narrative of an example	5 years

Measure 5.2.3 A: Address factors that contribute to specific populations' higher health risks and poorer health outcomes.
Foundational Capability Measure
Similar to Initial Measure 5.2.4 Required Documentation 2, except that reaccreditation requires one example of building resiliency in the face of climate change.

Purpose & Significance
The purpose of this measure is to assess the health department's efforts to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities. Differences in populations' health outcomes are well documented. Factors that contribute to these differences are many and include the lack of opportunities and resources, economic and political policies, structural racism and other forms of discrimination, and other aspects of a community that impact on individuals' and population's resilience. These differences in health outcomes require engagement of the community in strategies that develop community resources, capacity, and strength. The implications of climate change (e.g., increased extreme weather, air pollution) often disproportionately affect populations already at higher risk of poorer health outcomes. Consequently, health departments have a critical role in working with community to address and prevent those adverse effects.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Strategies 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. One example must address building resiliency in the face of climate change. The documentation must define the stakeholders', partners', or community's role in the strategy.	The two examples could be related to the community health improvement plan, but they do **not** need to be. Public health strategies implemented could 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. Policy changes may examine correcting historical injustices to provide fair and just opportunities for all to achieve optimal health. Policy changes considered may address the social and economic conditions that influence health equity including, for example, housing, transportation, education, job availability, neighborhood safety, and zoning. Building resiliency in the face of climate change could address policies or strategies, for example, to reduce greenhouse gas emissions or carbon footprints or to promote clean energy, with particular attention to how those policies might have an impact on communities that face higher health risks or other historical vulnerabilities. The efforts could also focus on mitigating the consequences of climate events (e.g., fires, extreme heat, hurricanes) among those who are disproportionately affected. Other examples could address strategies to address infrastructure changes, such a community design changes to mixed-use zoning, transportation redesign, or walkability. The initiatives could be led by another organization or department with which the health department was involved. 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	2 examples or narratives of examples	5 years

	decisions may be obtained from external sources such as Tribal Epidemiology Centers, state reports, or local sources. **DOCUMENTATION EXAMPLES** Documentation could include, for example, press releases; reports to the governing entity, interagency, or the community; or other documents that outline efforts, achievements, or implementation updates.		

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: Monitor and improve inspection activities.

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

Requirements	Guidance	Document(s)	Dated Within
1. Inspection protocols or policies reviewed and updated as needed. If the health department does not have the authority to conduct inspections then this requirement does **not** apply.	The intent is to demonstrate inspection protocols or policies have been reviewed and updated since the health department's last round of accreditation (either initial or reaccreditation). Updates may be formal (e.g., described as specific revisions to protocols), part of a quality improvement project (e.g., examining process flow changes for improved efficiency) or part of a more informal effort (e.g., general changes to inspection steps, staffing, etc.). If no updates are made, the coversheet may be used to describe the review process and why no changes were warranted. The health department may select the inspection areas or programs.	1 example or narrative of an example	5 years
2. Inspection activities of regulated entities reviewed to ensure that:	The intent of this requirement is to show that the health department has a process to review inspection activities (including both those that are the result of complaints and those that are conducted on a routine basis) to ensure they are carried out according to protocols.	Narrative or report	5 years

a. Regular and complaint investigations are performed in accordance with protocols. b. Inspections are performed according to defined frequency. The health department will provide both a description of the method for the review and the findings from the review. If the health department has no enforcement authority, describe the process to ensure that the health department is communicating to entities with enforcement authority about complaints that are received by the health department. (Element b does **not** apply.)	For required element a: The health department could describe, for example, how it reviews investigation reports to see that they follow the steps in the protocols (e.g., initiating investigations by logging concerns or complaints received, conducting initial investigations with reports of findings, or generating communications to regulated entities of what is needed or how to achieve compliance). The approach could include, for example, an audit of a random sample of investigation reports. If the health department has no enforcement authority, it could include, for example, how it ensures that complaints received by health department staff are handed off with appropriate timeliness to enforcement agencies. For required element b: The narrative or report could include, for example, how the health department confirms that investigations of regulated entities (e.g., food service establishments, drinking water, septic systems, recreational water places, hotels/motels, body art facilities, camps, schools/daycare, smoke-free ordinances, etc.) are carried out in the frequency defined by law or that its algorithms are correctly applied.		

Measure 6.1.2 A: Monitor and improve enforcement activities to assure accordance with protocols.
Foundational Capability Measure

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

Requirements	Guidance	Document(s)	Dated Within
1. Enforcement protocols or policies reviewed and updated as needed.	The intent is to demonstrate enforcement protocols or policies have been reviewed and updated since the health department's last round of accreditation (either initial or reaccreditation). Updates may be formal (e.g., described as specific revisions to protocols), part of a quality improvement project (e.g., examining process flow changes for improved efficiency) or part of a more informal effort (e.g., general changes to enforcement steps, staffing, etc.). If no updates are made, the coversheet may be used to describe the review process and why no changes were warranted. The health department may select the enforcement areas or programs.	1 example or narrative of an example	5 years

2. The process for reviewing enforcement activities of regulated entities to ensure that they are performed in accordance with protocols.	The intent of this requirement is to show that the health department has a process to review enforcement activities to ensure they are carried out according to protocols. This could include, for example, the process used to assess if protocols were followed appropriately when issuing notices of violation or compliance plans to regulated entities; whether follow up was performed according to schedule based on violations identified; whether appropriate action was taken to coordinate enforcement with other agencies, when appropriate; or whether appropriate steps were taken when violations persist, such as, suspension or revocation of licenses, closures, etc.	Narrative, process, or procedure	5 years

Measure 6.1.3 A: Identify and implement improvement opportunities to increase compliance.
Identical to Initial Measure 6.1.7.

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.

Requirements	Guidance	Document(s)	Dated Within
1. Assessment of enforcement programs, which must include: a. A summary of complaints, enforcement activities, **<u>and</u>** 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	The intent of this requirement is to show how the health department has assessed enforcement activities within the jurisdiction to identify opportunities for improvements that could foster increased awareness among the public, strengthen collaborative relationships or communication with other enforcement agencies, or improve compliance among regulated entities. 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	2 examples or narratives of examples	5 years

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.	processes (**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 **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	2 examples or narratives of examples	5 years

	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.	2 examples or narratives of examples	5 years

Measure 6.1.4 A: Ensure investigation/enforcement activities are carried out collaboratively and equitably.
Purpose & Significance The purpose of this measure is to assess the health department's capacity to strengthen its relationships with other entities to coordinate investigation or enforcement activities and to ensure that investigation or enforcement activities are equitably applied. Ensuring the equitable application of investigations or enforcement activities is a component of efforts to promote justice and remedy past injustices.

Requirements	**Guidance**	**Document(s)**	**Dated Within**

1. An improved relationship with another entity to coordinate investigation or enforcement actions.	The intent of this requirement is to provide an example of how the health department has improved relationships with other entities in order to better coordinate investigation or enforcement actions. An example of improving relationships with regulated entities would **not** meet the intent of this requirement. The health department could, for example, describe how it collaborated to improve information sharing across agencies or departments through meetings or correspondence before or while following up on a complaint or issuing enforcement actions. Other examples could address strengthening relationships to ensure enforcement actions are performed consistently or improved processes to promote compliance, such as collaborating to develop training or educational materials use among regulated entities. Either the health department or the other entity(ies) may have the enforcement authority.	1 example or a narrative of an example	5 years
2. A story of how the health department has taken steps to ensure investigation or enforcement activities are equitably applied. If the health department has no enforcement authority, the health department must provide an example of how it has collaborated with an entity with enforcement authority to address the equitable application of investigation or enforcement activities.	The story may consider equity aspects of conducting investigations or enforcement activities, or both. The story could include, for example, a description of successes or unsuccessful implementation, including what was learned about inequitable application of investigation or enforcement activities and plans to advance equity. Equitable considerations for investigations could include, for example, steps taken to ensure investigations receive equal response time or follow up, regardless of the location's income status or poverty level; working with landlords of low-income housing to promote equity among those without a voice; or working with the disenfranchised or unempowered to investigate or enforce lead abatement, nuisance violations, or safe drinking water. Equitable enforcement practices could also consider inequitable enforcement practices as a cause for disparities if, for example, people of color or low-income individuals receive a disproportionate level of fines or violations or if there is underenforcement in certain areas. If the health department has no enforcement authority, the example could describe a success story or learnings of how the health department worked with an entity(ies) with authority to address equitable application of investigation or enforcement practices or worked to strengthen relationships to examine enforcement practices that advance equity. The health department could, for example, form or participate in an equity taskforce or other collaboration to ensure enforcement actions do not harm, discriminate, or undermine the health of disparate or at-risk groups or to ensure enforcement practices are carried out in an equitable way or wrongdoers are held accountable using consistent standards or enforcement provisions.	1 example or a narrative of an example	5 years

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

Standard 7.1
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.
Similar to Initial Measure 7.1.1, except reaccreditation adds element e.

Purpose & Significance
The purpose of this measure is to assess the health department's participation in a collaborative process to develop an understanding of the population's access to needed health care services, including behavioral health and primary care. Collaborative efforts are required to assess the health care needs of the population of the Tribe, state, or community, as well as emerging issues which have implications on the health care delivery system or access to care among community members. This information could be useful in developing strategies or seeking support to expand services.

Requirements	Guidance	Document(s)	Dated Within
1. A collaborative assessment of access to health care that includes the following: a. A list of partners that were involved, which must include primary care and behavioral health providers. b. Analysis of data on populations who lack access or experience barriers to care. c. Analysis of data on the availability and gaps in services. d. Conclusions drawn for reasons why patients have barriers accessing care. e. Emerging issues related to	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. 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	1 collaborative assessment	5 years

access to care. Primary care and behavioral health care must each be considered within the assessment.	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, 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 may 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 from, for example, 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.		

	For required element e: Emerging issues that impact access to health care could include, for example, changes in the structure of the health care system; types and numbers of health care professionals being trained; changes in reimbursement structure, rates, or payment mechanisms such as accountable care organizations; developing care models (e.g., coordinated care organizations or convenient care clinics); and innovative use of electronic medical record data. The analysis of emerging issues could be part of the collaborative assessment or may be conducted by the health department through processes such as an environmental scan, SWOT, or forces of change (FOC) assessment with conclusions shared back to the collaborative group. **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 T/L: Implement and evaluate strategies to improve access to health care services.
Identical to Initial Measure 7.1.2.

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

Requirements	Guidance	Document(s)	Dated Within
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.	2 examples or narratives of examples	5 years

	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. • 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.	1 example or a narrative of an example	5 years

	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.		

Measure 7.1.2 S: Establish or improve systems to facilitate availability of high-quality health care.
Similar to Initial Measure 7.1.3.

Purpose & Significance
The purpose of this measure is to assess the **state health department's** efforts to improve existing systems or create new systems that are designed to improve the availability of high-quality health care for all. State health departments play an important role in establishing and improving mechanisms and systems to ensure access to health care across local jurisdictional boundaries. State health departments should be knowledgeable about health care financing systems and other system-wide initiatives in order to champion policy changes that impact access to high-quality care.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Efforts to develop or improve systems for ensuring the availability of health care.	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. 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.	1 example or a narrative of an example	5 years

	Collaboration could also include, for example, state health insurance plans or health care financers (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. **DOCUMENATION EXAMPLES:** Documentation could include, for example, reports or other summaries of activities, meeting minutes showing activities, testimony, presentations, grant applications, or grant implementation.		

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
Identical to Initial Measure 7.2.1.

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.

Requirements	Guidance	Document(s)	Dated Within

1. Multi-sector implementation of efforts to improve access to social services or to integrate social services and health care.	The intent of this measure is to describe how the health department, in partnership with others (e.g., healthcare, social service, and behavioral health providers), has implemented strategies or systems of care designed to connect clients to needed resources. This could include, for example, coordinating services for vulnerable populations through data exchange systems designed to identify individuals with high service utilization, working with providers to develop systems to assess social needs of clients, setting up systems for referrals, or developing coordination systems to integrate social service, behavioral health, public health, and primary care services, etc. The health department does **not** need to have convened or led the collaborative process, but it will have participated in the process to implement strategies. Examples that focus on the needs of the whole person might address prevention or upstream services, or integration of physical and behavioral health concepts. A one-time discussion would **not** meet the intent of the requirement which is to show collaborative implementation of efforts. Efforts could include, for example, implementation or collaborative plans for implementation, such as a submitted grant application or recently executed MOU, etc. **DOCUMENTATION EXAMPLES** Documentation could include, for example, • A signed Memoranda of Understanding (MOU) between partners to list activities, responsibilities, scope of work, and timelines. • A documented cooperative system of referral between partners that shows the methods used to link individuals with needed health care and social services. • Integration of screenings for Adverse Childhood Experiences (ACEs) or social determinants of health into primary care visits, or prioritization to focus on the most vulnerable or disparate subpopulations and their critical needs. • Documentation of outreach activities, such as use of social media campaigns, PSAs, or 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	2 examples or narratives of examples	5 years

	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.		

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

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.

Requirements	Guidance	Documents	Dated Within
1. Collaborative strategy to ensure continuity of access to needed care during service disruptions.	The intent of this requirement is to demonstrate how the health department collaboratively contributes to ensuring continuity of access to health care or social services in the community in the event of a disaster or disruptions to the delivery of services. Continuity of the health department's services or operation would **not** meet the intent of the measure. The documentation could be of a strategy that was implemented or of the plans for a strategy that could be used in the future. A one-time discussion would not meet the intent. Strategies could include, for example, contingency planning for the loss of a hospital, clinic, or service (e.g., planning for women's health services if Planned Parenthood or other providers discontinue services), establishing systems of care at alternate locations as a result of an emergency (e.g., outbreak, severe weather event, or catastrophic damage to the facilities of a major health care provider), ensuring access to prescription drugs if patients are temporarily unable to access pharmacies, creating alternate strategies for families to receive food support if meal programs at schools are disrupted, or providing assistance with housing in the face of rising unemployment rates due to an epidemic or emergency.	1 example or a narrative of an example	5 years

	Guidance		
	DOCUMENATION EXAMPLES: Documentation could be, for example, reports or other summaries of strategies planned or implemented; meeting minutes showing collaborative planning of strategies; work plans developed collaboratively with established roles, MOUs or other agreements; or submitted grant applications or grant implementation.		

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 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 efforts to recruit a qualified and diverse workforce and to build the pipeline for future public health workers. Health departments' success, as in all organizations, depends on the capabilities and performance of its staff. Recruitment strategies should focus on attracting and building a qualified public health workforce, which is necessary for a health department to function at a high level. A diverse workforce reflects the characteristics and demographics of the population using health department services and builds understanding of the perspectives and needs of the community. Collaborations with community groups and academic institutions can support both the recruitment for specific positions and the development of the public health workforce of the future.

Requirements	Guidance	Document(s)	Dated Within
1. Efforts to ensure a qualified and diverse workforce, which must include how the health department: a. Considers diversity, equity, and inclusion in recruitment efforts. b. Collaborates with other organizations for recruitment and to build the pipeline.	The intent of this requirement is to describe how the health department has worked towards a qualified and diverse workforce, both by helping to build the pipeline for future workers and in its specific efforts to recruit employees. For element a: The methods for recruitment could be tailored to encourage a diverse pool of applicants. For example, health departments could disseminate job openings by working with community partners or community members or by using targeted media outreach. 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.	Narrative	5 years

	For element b: The description about collaborative recruitment could include, for example, working with community partners or agencies as part of recruitment efforts geared towards those with lived experiences, such as people in recovery (substance use program areas) or breastfeeding mothers (peer counselors, MCH), etc. Health department staff may also be able to leverage their relationships with community members to recruit for positions (i.e., if staff are engaging with veterans or residents of a particular religious or cultural community, they may be able spread the word about job openings). The description will **also** describe efforts to build the pipeline for future workers. Working with youth organizations, libraries, community groups, elementary or high schools, schools or programs of public health, or other related academic and educational programs (e.g., public health nursing, public health laboratory services, public health informatics, health promotion, environmental public health, public policy, preventive medicine or other related study areas at community colleges, Tribal colleges, or other colleges and universities) is a means to promote public health as an attractive career choice. Promoting public health as a career choice could be accomplished through, for example, an internship or practicum agreement for hands-on learning, guest lecture on public health as a profession for students of any age, health department participation in a career fair, or developing or maintaining an Academic Health Department. Tribal health departments may describe their use of Indian Preference hiring policies. Describing use of EEO statements in job posting or EEO policies alone, does **not**, on its own, meet the intent of the requirement.		

Standard 8.2
The health department builds a competent public health workforce and leadership that practices cultural humility.

Measure 8.2.1 A: Develop and implement a workforce development plan and strategies.
Foundational Capability Measure
Required Documentation 1 is the same as Initial Measure 8.2.1 except that reaccreditation adds communication science in element c and adds a new element f.

Purpose & Significance
The purpose of this measure is to assess the health department's development and implementation of a workforce development plan that assesses the workforce's ability to maintain core public health, equity-focused, and administrative capabilities and identifies strategies to improve the workforce, as well as

efforts to support management and leadership skills. Health departments must have the capacity to perform core public health functions to meet the current and evolving needs of the community it serves. A competent workforce is armed with skills and experience needed to perform their duties to effectively carry out the health department's mission and advance the health of the community. This includes ensuring the workforce is equipped to promote equity, diversity, and inclusion. Professional development activities can assist current and future health department leaders to employ state-of-the-art techniques to lead people and organizations.

Requirements	Guidance	Document(s)	Dated Within
1. A health department-specific workforce development plan that includes: a. A description of the current capacity of the health department both as a whole and within each of its sub-units. b. An organization-wide assessment of current staff capabilities against an adopted set of core competencies. c. A description of gaps in capacity or capability as identified through the findings from a and b above. The description must address the following areas: i. Communication science. ii. Technology advances. iii. Other gaps identified by a and b above. d. Findings from an equity assessment which considers staff competence in the areas of cultural humility,	The workforce development plan articulates specific objectives and strategies the health department plans to undertake to achieve its desired future workforce, based on considerations of the health department's current gaps in capacity and capabilities, particularly within areas in which the field is advancing. For required element a: The health department could use various tools or assessments to understand the current collective capacity of the department as a whole and its sub-units. Methods could include, for example, calculating health department current and projected needed staffing capacity compared to population size; benchmarking to other health departments performing similar functions within similarly sized jurisdictions; or using tools or resources such as, the Uniform Chart of Accounts, PH WINS (Public Health Workforce Interests and Needs Survey), or Staffing Up: Determining Public Health Workforce Levels Needed to Serve the Nation. For required element b: A core competency assessment could include, for example, a nationally recognized model (e.g., the "Core Competencies for Public Health Professionals" from the Council on Linkages Between Academia and Public Health Practice or the skills outlined in the needs assessment of PH WINS), state-developed competencies, specialty-focused competencies (e.g., nursing, epidemiology, public health preparedness, informatics, and health equity competencies), or an internally developed set of competencies. Health departments could also use modified or condensed versions of existing competency sets or combine competency sets, to be better tailored to their organizations. A core competency assessment could be conducted on behalf of the health department by a consultant or another entity as long as the assessment provides results specific to the health department's staff. For required element c: The intent of this requirement is that the health department consider gaps in the existing capacity or capability of its workforce identified as part of elements a and b. For example, communication science advances address how science is communicated to lay	1 plan	5 years

diversity, or inclusion. e. Plans to address at a minimum two of the gaps in capacity or capabilities identified in (element c) or the findings of the equity assessment (element d); for each gap, documentation must include: i. Measurable objectives. ii. Improvement strategies or activities with timeframes. f. A description of how the workforce development plan links to the strategic plan.	audiences, for example, use of "flatten the curve" imagery amid COVID-19 or other visual tools. It also includes other means to expand reach or communications messages, including use of social media platforms. 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, emergency preparedness or response, public health sciences (e.g., epigenetics), climate change, or innovation methods, etc. For required element d: The intent of this requirement is that the health department consider the workforce's competence related to health equity. While health departments are encouraged to assess cultural humility, diversity, and inclusion, demonstrating a minimum of one is required. Aspects of this competence could be assessed through, for example, the Cultural and Linguistic Competency Policy (CLCPA) self-assessment from the National Center for Cultural Competence, an assessment against the Culturally and Linguistically Appropriate Services (CLAS) standards, the Health Equity at Work: Skills Assessment of Public Health survey, or another assessment tool. It could also reflect an emphasis on cultures in the health department's jurisdiction (e.g., cultural traditions of American Indians, immigrant communities, etc.). The equity assessment could also be one component of a broader assessment (e.g., equity-related questions in PH WINS or the Core Competencies assessment). The workforce development plan, or an appendix, will include a summary of the findings from this assessment. For required element e: Plans will relate to the gaps in capacity or capabilities described in element c **<u>or</u>** 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. For required element f: The intent of this requirement is that the workforce development plan aligns the workforce towards achieving the strategic goals of the health department. The workforce development plan does **<u>not</u>** need to link to all elements of the strategic plan, but it will		

	show where linkages are appropriate for effective planning and implementation. Linkages could include, for example, building staff capacity (e.g., recruitment) or capabilities (e.g., through professional development or training opportunities) based on strategic priorities or objectives. The coversheet may be used to clarify and describe linkages.		
2. Description of the impact of implementing the workforce development plan.	The intent of this requirement is to describe outcomes from implementing the workforce development plan. The description could include an example of successful or unsuccessful implementation, including what was learned based on the implementation. It could describe, for example, how efforts to address workforce capacity and capabilities have translated into improved organizational operations (e.g., improved employee satisfaction or increased the ability of the health department to administer contracts, apply for grants, or communicate effectively) or the programs, services, and interventions in the community (e.g., enhancing the ability of the health department to work with populations of higher risk, or strengthening health promotion activities in the community). Or, for example, it could describe a QI process used to improve the workforce development strategies.	Narrative description	5 years
3. The process for developing management/leadership skills as part of succession planning.	The intent of this requirement is to describe efforts to develop future managers or leaders. While training (e.g., executive management seminars or programs, graduate programs in leadership/management, participation in national or state-based leadership institutes) could be part of that effort, the process could also include policies or processes which support a continuum to support the future workforce. The health department could describe, for example, opportunities for staff to build leadership or management skills by being responsible for tasks of increasing complexity; rotating through other positions or serving in those positions in an interim or acting basis; or conducting assessments of management skills (e.g., 360 degree evaluations where staff are assessed by their peers, the individuals they supervise, and those they report to); and providing coaching where appropriate. The process could also describe deliberate efforts to strengthen skills that could include, for example, negotiation skills, strategic management, emotional intelligence, adaptive leadership, change management, intercultural or intergenerational management, collaborative intelligence, handling conflict, coaching and mentoring skills, communications skills for managers, leadership styles, effective networking, and leading teams and collaborations.	Narrative description	Current process

Measure 8.2.2 A: Build a supportive work environment.
Required Documentation 1 is identical to Initial Measure 8.2.3 Required Documentation 1.

Purpose & Significance
The purpose of this measure is to assess the health department's efforts to create an organizational culture and work environment that is supportive of the staff and to evaluate and improve 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.

Requirements	Guidance	Document(s)	Dated Within

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 b. Employee recognition c. Employee wellness d. Inclusive culture	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, breastfeeding/lactation support, etc. 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, 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.	1 policy or set of policies	5 years
2. Efforts taken to improve the work environment or improve employee satisfaction. At least one example must demonstrate taking action as a result of staff feedback/worker satisfaction assessment.	Examples could address improvement efforts in areas including, for example, work-life balance, employee recognition, employee wellness, or staff inclusion. Efforts could include, for example, completed QI projects, revised policies or procedures, staff events, new or revised communication methods from leadership, or other activities to build a supportive workplace. At least one example will be based on the results of a staff assessment, which could be through a formal mechanism (e.g., a staff-wide survey) or an informal one (e.g., an employee suggestion box).	2 examples or narratives of examples	5 years

	The second example could also be based on employee feedback or could demonstrate improvement efforts identified through other methods, such as the regular review and updating of supportive workplace policies or analysis of retention/turnover rates. In a centralized system, the state health department could include examples related to staff serving local jurisdictions.		

Measure 8.2.3 S: Support efforts of Tribal and local health departments to strengthen the public health workforce.
Similar to Initial Measure 8.2.4, except reaccreditation requires working with multiple Tribal or Local health departments and only one example.

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.

Requirements	Guidance	Document(s)	Dated Within
1. Support provided to multiple Tribal or local health departments to be responsive to their needs regarding strengthening the workforce. If there is at least one Tribal health department in the state, then the example must include support to both Tribal and local health department(s).	The intent of this requirement is that support is provided to multiple health departments based on their needs to bolster their workforce, rather than a one time or one-way communication. A broad workforce development effort—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 multiple Tribal/local health department(s) or efforts to facilitate placements with Tribal/local health departments. Similarly, an effort to work directly with just one health department would **not** meet the intent. 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, • Funding provided to multiple health departments across the state to support workforce capacity building or educational/professional development activities or other resources (e.g., access to learning management systems). • Collaborations formed with schools 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.	1 example or a narrative of an example	5 years

	• Conducting workforce assessments and using results for collective problem-solving to address gaps in workforce capacity or capabilities among multiple Tribal and/or local health departments (e.g., convening a group of health departments to work collectively on assessing and meeting workforce demands). 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.		

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: Implement the performance management system.
Foundational Capability Measure
Required Documentation 1 is identical to Initial Measure 9.1.1.

Purpose & Significance:
The purpose of this measure is to assess the health department's use of performance management practices in assessing performance and identifying and managing opportunities for improvement. A performance management system encompasses 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.

Requirements	Guidance	Document(s)	Dated Within
1. A department-wide performance management system, which includes:	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	1 performance	5 years

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.	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).	management system	

The health department could, for example, set their performance objectives based on a combination of the following:

- National, state, or other scientific guidelines (e.g., Healthy People, state program requirements, or accreditation standards and measures).
- Funders' performance or reporting requirements (e.g., outlined in grant requirements).
- Benchmarks derived from peer organizations (e.g., neighboring health departments or health departments of similar size/characteristics).
- Expectations of the public or leadership (e.g., public health performance objectives set by the governing entity).
- Organizational or programmatic plans or workplans (e.g., targets established through strategic plan, health improvement plan, or workforce development plan; or targets established through program-level workplans).

Documentation may demonstrate a sub-set of the performance manage system through screenshot(s) or other documentation. The documentation does **not** need to show every goal and objective, but will provide a view of the breadth of the goals included in the performance management system.

For required element b:

The functional description of the performance management system could be a description, policy, or plan (separate plan or integrated with the QI plan). It will describe how the following processes generally occur, but does **not** need to go into detail about each individual objective. For example, in describing how staff enter data into the system, it would be sufficient to list the methods used to collate data into the system without indicating which method applies to each specific objective. The description will include the process for how staff will do each of the following:

i. Enter data in the system. Performance measurement data can be derived from multiple data systems or data collection processes. Some could be directly transferred into the performance management system from another data source (e.g., if there is a connection to HR, financing, or surveillance data systems) or could be entered by staff.
ii. Analyze data. This could include, for example, how data are analyzed to determine whether progress has been made towards meeting the objectives.
iii. Communicate results on a regular reporting cycle. This could include, for example, regularly summarizing data on performance objectives (e.g., monthly, quarterly, annually, etc.) and sharing this information with stakeholders (e.g., the health department director, members of the governing entity, staff, or members of the public). Documentation of progress reporting could include, for example, a

	dashboard accessible to others, quarterly reports sent to stakeholders, newsletters, meeting agendas and minutes, or presentations. iv. Use data to guide decision making. The health department could use performance management data analyses to, for example, guide decisions on where resources should be allocated or adjusted to improve efficiencies or effectiveness; or identify an unmet community need. v. Use data to facilitate continuous quality improvement. Analysis of performance management data could lead to the identification of a quality improvement project, for example. For required element c: Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities, or the mission or vision of the department. The performance management system does **not** need to link to all elements of the strategic plan, but it will show where linkages are appropriate for effective planning and implementation. A statement simply stating the performance management system is aligned to the strategic plan would **not** suffice. The coversheet may be used to clarify and describe linkages.		
2. Performance management system implementation story that includes customer feedback.	The story could describe successes or unsuccessful implementation, including what was learned based on the implementation of the performance management system. The story could describe, for example, how performance data were used to inform a health department decision that had positive effects on the department or community, implementation of quality improvement processes, etc. In the context of this requirement, "customer" refers to the group impacted by the performance management goal. In this sense, customers could refer to partners or key stakeholders or, if it's an administrative goal, the customers could be internal to the health department. The story could be tied to the quality improvement project (required within 9.1.3 A) or highlight another story of using customer feedback as part of performance management system implementation.	1 example or a narrative an example	5 years

Measure 9.1.2 A: Establish a process that guides health department quality improvement efforts across the department.
Identical to Initial Measure 9.1.4.

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.

Requirements	Guidance	Document(s)	Dated Within

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 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.	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 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.	1 plan	5 years

	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 9.1.3 A: Implement quality improvement projects.
Foundational Capability Measure
Identical to Initial Measure 9.1.5, except reaccreditation requires examples using customer satisfaction data and a population-based example.

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. Health departments can demonstrate their commitment to continually improving how they serve their communities by incorporating customer satisfaction data and conducting projects focused on population-based health promotion activities.

Requirements	Guidance	Document(s)	Dated Within
1. Completion of quality improvement (QI) projects that demonstrate the following: a. How the opportunity for improvement was identified. b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement. c. Use of a QI method.	The intent of this requirement is for QI projects that have gone through at least one full project cycle. Projects that are still in-process at the time of documentation submission would **not** meet measure requirements. Examples will focus on improvement of existing projects, programs, or efforts rather than on use of QI tools to plan new projects, programs, or initiatives. Programmatic areas could include projects focused on improving existing processes related to, for example, engagement of partners or community members in the community health assessment process; reducing youth vaping rates in high-risk communities; revising intake processes for community members using health department services; or increasing community participation in a walking challenge intended to promote physical activity. Program examples could also focus on exploring root causes or barriers to streamline or improve existing	2 examples or narratives of examples	5 years

d. Use of QI tools to better understand or make decisions about: i. The current process, effort, or gap. ii. Root cause(s). iii. Possible solutions. iv. Prioritization/selection of solutions for implementation. e. A description of the outcomes of the QI project, including progress toward the measurable objective(s) established in required element a. The description must include data used to determine whether the project's objective(s) was met and identify next steps resulting from the project. One example must show use of customer satisfaction data. One example must be a program area that focuses on population-based health promotion, protection, or improvement efforts to address a community health issue.	processes that could impact health equity. This could include QI projects aimed to, for example, increase use of farmers markets in identified food desert areas, improve transportation systems, or streamline existing coordination of care processes using Community Health Workers or Community Health Representatives. Administrative areas could include, for example, projects focused on administrative elements or activities related to individual programs or could relate to administrative tasks that affect the entire health department. Administrative areas could include, for example, improving timesheet approval processes, improving recruitment processes to increase the diversity of the hiring pool, new employee onboarding processes, or the contracts management process (for the health department as a whole or for the environmental health program, for example). For required element a: Identification of problems or opportunities for improvement could occur through use of data from, for example, the department's performance management system, other program or administrative data, audit findings, staff observation, or staff or customer feedback. For required element b: Those engaged in the project will establish objectives to measure progress on what they are trying to accomplish. These statements are sometimes referred to as AIM Statements. Objectives could include, for example, within six months, reducing the number of days it takes to inspect and approve a new private septic system from five business days to three business days; or increasing from 40% to 60% the reach of a health education campaign about the benefits of the HPV vaccine among adolescents over the course of two months. For required element c: Quality improvement methods could include use of, for example, Plan Do Study/Check Act (PDSA/PDCA); Six Sigma's Define, Measure, Analyze, Improve, Control (DMAIC); or Kaizen, lean, or other recognized QI methodologies. For required element d: QI tools appropriate for a given improvement model will vary based on the method selected and the type or problem identified. To examine the current process (i), the health department will document how the current process works and identify potential issues or opportunities for improvement. QI tools could include, for example, flowcharting or process mapping to document the way in which the process under study is currently operating. To have the greatest opportunity for improvement, the health department will uncover root causes (ii) and factors contributing to the issue under review. QI tools could include, for		

	example, affinity diagrams, brainstorming, flow charting, fishbone diagrams, check sheets, control charts, force field analyses, Gantt charts, interrelationship diagrams, logic models, pareto charts, and swim lane maps. There are generally many possible solutions (iii) to a given problem. The health department will identify several possible solutions in order to 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.		

Measure 9.1.4 A: Nurture a culture of quality across the health department.

Purpose & Significance:
The purpose of this measure is to assess the health department's ongoing efforts to build its quality improvement and performance management capacity and engrain continuous quality improvement into its culture. A culture of quality is nurtured when health department leadership and staff at all levels are engaged in a deliberate approach to continually assess and improve performance. Engagement across the 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.

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

	include, for example, including in the performance management system objectives aligned to specific strategic planning or CHIP priorities or objectives. For required element d: Describe how the health department director and other leadership foster a performance-based department focused on supporting the implementation of department-wide performance management/QI. The narrative could describe, for example, leadership engagement in establishing and/or updating the system, contributing resources or funding to support the performance infrastructure (e.g., hiring of dedicated staff, enabling staff time for performance management/QI activities, providing learning and professional development opportunities for staff, etc.), or leadership's recognition of staff for contributions to performance management/QI.		

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: Base programs and interventions on the best available evidence.
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, as well as the use of evaluation to improve process, programs, or interventions. Health departments should be aware of practices that have been found to be effective through research or experience in other communities and incorporate them into their processes, programs, and interventions, as appropriate. The use of these types of practices helps assure that health department resources are being allocated and applied as effectively as possible.

Requirements	Guidance	Document(s)	Dated Within
1. Process for using the best available evidence. The narrative must include: a. A description of the health department's process to look for evidence-based or promising practices when a program or intervention is developed or revised. b. A description of the health department's general practice	The intent of this requirement is for the health department to describe how they are aware of and apply research or practice-based programs, processes, and interventions within their jurisdiction. For required element a: The description could include, for example, how templates or checklists are used by staff when developing or revising a program, process, or intervention. The description could also include, for example, the types of sources of research or practice-based information that are considered. The source of research or practice-based information could be formal, such as peer-reviewed journals, or informal, such as from a peer health department. Some additional potential sources could include, for example, The Guide to	Narrative description	Describe the current process

to customize the evidence-based or promising practice to be appropriate for the community and the community's particular characteristics.	Community Preventive Services, NACCHO Model Practices, "What Works for Health," the Trust for America's Health's Promoting Health and Cost Control in States initiative, literature reviews, consultants, academia, researchers, other health departments, or other experts on a particular topic. Tribal health departments could select sources from the Indian Health Services (IHS) or other Tribal-specific research sources. For required element b: The health department will describe its general process for tailoring evidence-based or promising practices to the process, program, or intervention to the community. For example, if a small or rural health department wanted to use a practice-based intervention that was originally implemented in a large, urban community, they could consider what adaptations would make that example effective in their own jurisdiction. The description could also explain the process for adapting a research-based example of a health promotion effort designed for a specific cultural group to use for a different population group. 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.		
2. Improvements made based on the evaluation of a program, process, or intervention.	The documentation or description will include a summary of the evaluation findings and resulting improvements to the program, process, or intervention. The data themselves used to inform the improvement are **not** required, but a summary of results will be provided. Quantitative or qualitative data could be used to evaluate a program, process, or intervention to determine if it is achieving its intended outcome. Evaluations could be conducted by the health department or by other entities. **DOCUMENTATION EXAMPLES** Documentation could include, for example, improvements described within an evaluation report or presentation, program or project report submitted to a funding organization, or other summary of improvements to a program, process, or intervention based on an evaluation.	1 example or a narrative of an example	5 years

Measure 9.2.2 A: Foster innovation
Identical to Initial Measure 9.2.4.

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-sectorial 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.

Required Documentation	Guidance	Number of Examples	Dated Within

1. Effort to foster innovation skills or practices/processes.	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 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.	1 example or a narrative of an example	5 years

Measure 9.2.3 T/S: Foster research.
Identical to Initial Measure 9.2.5.

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.

Required Documentation	Guidance	Number of Examples	Dated Within
1. Involvement with other researchers to foster research.	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	1 example or a narrative of an example	5 years

	health of Americans Indians and Alaska Natives. **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.		

Measure 9.2.4 S: Provide support to Tribal and local health departments in applying relevant research results or evidence-/practice-based learnings.
Identical to Initial Measure 9.2.6 S.

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

Required Documentation	Guidance	Number of Examples	Dated Within
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.	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.	1 example or narrative of example	5 years
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	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	2 examples or narratives of examples	5 years

evidence-/practice-based learnings.	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 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: Adopt a department-wide strategic plan.
Foundational Capability Measure
Identical to Initial Measure 10.1.2.

Purpose & Significance
The purpose of this measure is to assess the health department's adoption of a department strategic plan. A strategic plan defines and determines the health department's roles, priorities, and direction over a set period of time. The strategic plan provides a roadmap to foster a shared understanding among staff to align towards contributing to what the department plans to achieve, how it will achieve it, and how it will know whether efforts are successful. The strategic plan takes into account leveraging its strengths, including the collective capacity and capability of its units towards addressing weaknesses and challenges through processes linked within the performance management system. The strategic plan outlines the health department's contributions towards improving health outcomes outlined in the community health improvement plan.

Requirements	**Guidance**	**Document(s)**	**Dated Within**
1. A department-wide strategic plan, which must include: a. The health department's mission, vision, and guiding principles/values for the health department. b. Strategic priorities.	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	1 strategic plan	5 years

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. If the health department is part of a super health agency or umbrella agency, the health department's strategic plan may be part of a larger organizational plan. If that is the case, the plan must include a section that addresses the health department and includes the required elements of the plan specific to the health department. If the plan of the super health agency or umbrella agency does not include the required elements for the health department, then the health department must document that it has conducted an internal health department planning process and adopted a health department specific strategic plan or supplemented the plan to address required elements above.	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 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 10.1.2 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.

Required Documentation	Guidance	Document(s)	Dated Within
1. Implementation of the strategic plan. At least one of the examples must address strategic allocation of resources. If the plan has been adopted within the year, examples may reflect implementation of a previous plan.	The intent of this requirement is to describe specific examples of how the health department implemented its strategic plan. A workplan indicating which goals have been completed alone would **not** meet the intent of the measure. The strategic plan will be resourced to effectively implement goals. Resources could include, for example, personnel (e.g., dedicated staffing or time allocated), financial contributions (e.g., budget allocations towards strategic goals/priorities), submitted grants aligned with strategic goals, shared service agreements or partnerships to expand the health department's capacity to achieve strategic goals, etc.	2 examples or narratives of examples	5 years
2. A description of the health department's approach to	The intent of this requirement is that the health department routinely inform the governing entity on progress towards the implementation of the strategic plan. Regular communication fosters	Narrative description	Describe current

engaging with the governing entity and staff at all levels about the implementation of the strategic plan.	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 addition, involving staff at all levels of the health department will support robust implementation of the strategic plan. The narrative will describe how it ensures that health department staff, including frontline (non-managerial/supervisory), mid-level, and leadership (managerial/supervisory) staff, are aware of the department's progress towards strategic goals. The narrative could also describe the department's approach to helping all staff understand how their work contributes to the implementation of the strategic plan.		process

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

Measure 10.2.1 A: Manage operational policies including those related to equity.
Required Documentation 2 & 3 are identical to Initial Measure 10.2.1 Required Documentation 2 & 3.

Purpose & Significance
The purpose of this measure is to assess the health department's process for reviewing, revising, and sharing health department policies and procedures with staff, as well as the incorporation of inclusion, diversity, equity, 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. Regular review and revision of those policies and procedures is important for continuous quality improvement. 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.

Required Documentation	Guidance	Document(s)	Dated Within
1. A description of how operational policies or procedures, **<u>including</u>** human resource policies or procedures, are reviewed and revised on a routine basis. The narrative must include: a. The process and frequency of review **<u>and</u>** revision. b. How the department addresses changing or	Operational policies are intended to direct the operations of the health department as a whole. Program policies would **<u>not</u>** meet the intent of this measure. For element a: The description could include, for example, the schedule for how often policies and procedures are reviewed, how the health department keeps track of when polices or procedures are due for review, and who is involved in the review process. For required element b: Changing or emerging considerations could be related to, for example, legislative changes (e.g., updates to the IRS' mileage reimbursement rates or labor laws), modified policies or procedures about the use of technology (e.g., telework policies),	Narrative description	Describe current process

emerging administrative or management consideration. c. How changes are communicated to staff.	organizational restructuring, workforce diversity, change management, leadership development practices, etc. The description could address, for example, how considerations are raised and what process steps occur to address such considerations within operational policies or procedures. For element c: Methods to communicate changes to staff could include, for example, memos or emails to staff with revised policies and procedures attached or with the location of electronic or hard copy versions. In centralized systems, state health departments will describe how changes that apply to staff serving local jurisdictions are communicated 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.	1 list of terms with definitions	5 years
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.	1 example or a narrative of an example	5 years

	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 secure information management infrastructure to support strategic goals.
Foundational Capability Measure
Required Documentation 1 is identical to Initial Measure 10.2.4 Required Documentation 1.

Purpose & Significance
The purpose of this measure is to assess how the health department protects the security of its data systems and confidential information from risks and potential threats, as well as ways the health department has leveraged its information management systems to advance strategic goals. Use of information management systems can be a powerful tool to support efficient and effective programs and operations, as well as the flow of information. Lack of attention to privacy and security controls can lead to breaches in federal, states, or local laws; diminished credibility or trust among community members; and vulnerabilities in maintaining operations and provision of services. Health departments should maintain protections for safe storage, handling, and access to classified, confidential, and sensitive information (e.g., client records, surveillance data, and human subjects research sensitive information).

Required Documentation	Guidance	Document(s)	Dated Within
1. An adopted, department-wide information security policy that includes the following: a. A description of the requirements for password complexity **__and__** lifespan. b. A process for ensuring physical security of information **__and__** network security. c. A policy for data that require additional privacy protection, which includes: i. A process for identifying such data, which must, at minimum, include all data that are covered by applicable **__federal, state, and local__** privacy protection regulations for handling confidential data.	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 requirement is **__not__** confidentiality of employee records. Health departments could use government-wide (i.e., state, city, or county) or super-health agency or umbrella agency policies and procedures. Tribal policies could be government-wide, or Tribal-wide. These policies and procedures could demonstrate conformity with the measure if they apply to the health department. For required element a: Password complexity and lifespan are some of the first lines of defense against information security risks. The information security policy will include guidance and expectations for password complexity, as well as lifespan of passwords or established password expiration timelines. For required element b: Physical security of information requires procedures to ensure that information is not accessed by unauthorized parties. Physical security could be maintained through, for example, the use of a secure server room; locked doors or windows; video surveillance; limited access among key staff; device and endpoint management; protections for environmental hazards (e.g., climate-controlled secure server rooms or use of surge protectors); etc. For required element c:	1 policy or set of policies	5 years

ii. A process for user access management for electronic data and data systems. iii. A process for maintaining confidentiality of paper versions of those data.	The process for privacy protection could be part of a separate policy. Confidentiality policies may address processes for handling, storing, managing, and disposal of confidential data, which could include, for example, Protected Health Information (PHI) as regulated under Health Insurance Portability and Accountability Act (HIPAA), Personally Identifiable Information (PII), Sensitive Identifiable Human Subject Research regulated by the Federal Policy for the Protection of Human Subjects (or "Common Rule"), or other sensitive information, in accordance with laws, rules, and regulations within the health department's jurisdiction. i. Knowing which data are sensitive or mission-critical allows the health department to establish appropriate security controls for of those data and systems. As appropriate, the health department could classify an entire system (e.g., a surveillance system) or it could classify certain fields within the system. Classifications could include, for example: • Sensitive data are data that are not meant to be made public. Sensitive data systems could include, for example, immunization data registries, reportable disease records, or vital records. • Mission-critical data are any data or systems that, if compromised or unavailable to users for long periods of time, would prevent the health department from being able to conduct its business functions. Mission-critical data or systems could include, for example, systems for collecting payment for environmental health licenses or permits. ii. User access management refers to the process for ensuring only users who need access to sensitive and mission-critical data and data systems are granted access to those data and systems. The policy could describe the processes for, for example, determining appropriate users; ensuring those users are the only ones with access; and disabling the access of users who do not require access to sensitive and mission-critical data and systems. iii. Confidentiality of paper versions of data could include, for example, use of locked file cabinets or storage areas/facilities, restricted access among key personnel, or disposal of confidential or protected health information in accordance with HIPAA.		
2. Improvement to information management systems to advance strategic goals.	Advancing strategic goals could relate to, for example, the health department's mission or strategic plan, or the community health improvement plan. Examples could directly tie to achieving strategic plan goals (e.g., if the strategic plan contains goals associated with expanding the community's awareness of the health department, the health department could redesign the health department's website or social media capabilities; or if a community health improvement plan priority relates to reducing foodborne illness, the health department could	1 example or a narrative of an example	5 years

	improve the information systems that are used to monitor restaurant inspections). Examples could also broadly address how information management has supported monitoring implementation of strategic plan or community health improvement goals, for example, designing and implementing an information management system infrastructure to foster awareness of strategic goals or transparency of progress and/or reporting mechanisms.		

Measure 10.2.3 A: Ensure facilities are accessible.
Identical to Initial Measure 10.2.5 Required Documentation 2.

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

Required Documentation	Guidance	Document(s)	Dated Within
1. Assurance of accessibility to health department's facilities or services when services are provided offsite or in a temporary location.	The intent of this requirement is that the health department consider accessible services provided in offsite or temporary locations, based on Americans with Disabilities Act (ADA) requirements. 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.	1 example or a narrative of an example	5 years

Measure 10.2.4 A: Oversee financial management systems.
Foundational Capability Measure

Required Documentation 1 is identical to Initial Measure 10.2.6 Required Documentation 2; Required Documentation 2 is identical to Measure 10.2.6 Required Documentation 4; Required Documentation 3 is identical to Initial Measure 10.2.7 Required Documentation 2; Required Documentation 4 is identical to Initial Measure 10.2.7 Required Documentation 3.
Purpose & Significance The purpose of this measure is to assess the health department's accountable financial stewardship and oversight of agreements with other organizations, as well as its audit process. This includes the health department's ability to demonstrate its use of funds provided through grants and contracts, as well as the health departments' 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. Preventing or addressing audit findings or findings related to being a high-risk grantee are other important components of accountability.

Required Documentation	Guidance	Document(s)	Dated Within
1. 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	**DOCUMENTATION EXAMPLES** Documentation could include, for example, letters or emails that officially and formally describe concerns from funding agencies (e.g., federal agencies, state health department funding to local health departments). The signed statement attesting to the health department not being a high-risk grantee could be, for example, as simple as a signed memo from the health department director, a deputy or assistant director, or a finance officer.	All, as appropriate	5 years

deputy or assistant director, or a finance officer attesting to that fact.			
2. Improvements made to the health department's processes for managing written agreements with other organizations **or** for demonstrating compliance with requirements from its funders.	The intent of this requirement is to demonstrate improvements made to processes related to written agreements, contracts, or grants. This could include, for example, standardizing or improving processes for receiving invoices and paying contract fees and invoices on time; receiving reports from contractors and ensuring services are rendered; or issuing or receiving resolution of corrective action reports to the contractor if the services are not rendered or otherwise holding others accountable for compliance with agreements to the health department. Examples could also include, for example, steps the health department is taking to improve its processes for monitoring and reporting on work the health department does as part of meeting funding requirements (e.g., spend-down processes). Improvements do not need to be complicated, but could include, for example, assessing timeliness of payment by calculating the proportion of invoices paid on time and using data to identify areas to improve efficiencies, increasing accuracy in accounting and budgeting processes, implementing a process to evaluate reports received from contractors for services rendered, conducting a comparison with the scope of work or expected deliverable, or establishing a process for requiring a corrective action report if services are not rendered. **DOCUMENTATION EXAMPLES** Documentation could include, for example, improvements discussed during a meeting or summarized in a report or quality improvement project.	1 example or a narrative of an example	5 years
3. External department-wide financial audit reports. The audits must be full health department audits (**not** single program audits).	The health department's audit could be part of a larger audit of the governmental unit (for example, umbrella agency, super agency, county government, or state government) of which the health department is a part. **DOCUMENTATION EXAMPLES** Documentation could include, for example, county audit reports that include a section on the health department's finances, or a stand-alone, independent audit of the health department.	2 examples	5 years (two most recent audits)
4. Improvement steps identified based on findings from the most recent audit. If the most recent audit did not include findings to address (i.e., a clean audit), the health department must indicate that in the coversheet.	The example provided will include steps, or corrective actions, the health department is taking to address audit findings. A summary of steps identified or taken to address the findings will be accepted. The intent of this requirement is to show that the health department is planning steps to address findings in the audit. It is **not** necessary for those steps to have been completed by the time the documentation is submitted. Examples of improvement steps could include, for example, evaluating current processes to identify areas that need improvement, reviewing policies to ensure they comply with requirements, strengthening internal controls to improve timeliness or tracking requirements, providing training to staff on policies and regulations, defining clear roles and responsibilities, etc.	1 example or a narrative of an example	3 years

Measure 10.2.5 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 maintain financial sustainability to support its infrastructure or to sustain, enhance, or develop processes, programs, and interventions. It is important 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. Financial resources should be maximized by leveraging current funds to increase resources available for public health.

Required Documentation	**Guidance**	**Document(s)**	**Dated Within**
1. Efforts to ensure the health department's sustainability. One example must be an effort to evaluate financials and the other must be an effort to seek additional financial resources or increase efficiencies. At least one example must show engagement with the governing entity.	The intent of this requirement is that the health department regularly applies a business approach to support its financial infrastructure, which includes both evaluation of financials and seeking additional funding or improving financial sustainability by increasing efficiencies. Evaluation of financials through a business lens could include, for example, examining performance-based budgeting or Return on Investment (ROI) of services, or considering concepts of public health economics (e.g., supply/demand factors in consideration of other service providers within the health department's jurisdiction or competitor analysis), or establishing a business plan or strategic financial plan (e.g., capitol or marketing plans). Efforts to seek additional financial resources could include, for example, budget increase requests, budget revision requests, or grants. Examples could also address efforts to sustain funding amid budget reductions (e.g., securing funding 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. Engagement with the governing entity could include, for example, requesting funding from that entity; having the governing entity, in conjunction with the health department, communicate with others about the need for additional financial resources for the health department; or communicating to the governing entity about the evaluation of the financials and needs.	2 examples or narratives of examples	5 years
2. The process for flexible financial management during uncertain or unplanned events. The process must address: a. How the approval process will be expedited for rapid program development and execution or program	The health department will provide a written process for how it adapts its standard procedures to manage uncertainty or unplanned events. The process could be outlined as a written approach or policy/procedure that considers prioritizing maintenance of essential services during uncertain times or events, such as, a public health emergency or severe budget cuts. The intent of this requirement is that the process serves as a guide to outline how decisions will be made about how essential services will be resourced to sustain critical operations. The process could also describe how the health department adapts to new opportunities, for example, the creation of a new source of funding for health in the community.	1 process	5 years

revision to address unanticipated challenges or opportunities. b. How resources will be allocated in response to an unplanned event through a health equity lens or in consideration of populations with higher health risks. c. How the approval process for written agreements with other entities will be expedited.	For required element a: The process could outline how the health department is able to bypass normal processes to create new, or revise existing, programs, if warranted under a given situation. For required element b: The process could include, for example, how sub-populations or groups will be identified and resources mobilized to address disparities and those disproportionately affected by unplanned events. For required element c: The process could address, for example, expediting agreements with other governmental entities or organizations (e.g., through intergovernmental disaster response coordination or other agreements, such as MOUs/MAAs in place in the event of an emergency).		
3. Implementation of flexible financial management strategies or initiatives for uncertain or unplanned events (based on the process described in Required Documentation 2).	Examples could reflect executed agreements with other agencies (e.g., contracts, MOUs/MAAs) for contingency use in the event of uncertainty or an unplanned event (e.g., equipment, locations, or personnel) or implementation of the process to expedite rapid program development by by-passing standard approval processes. Considerations for populations with higher health disparities could take into account additional communication methods or transportation methods (e.g., those living in remote areas), if traditional methods should be disrupted.	1 example or a narrative of an example	5 years

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.
Identical to Initial Measure 10.3.1.

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.

Required Documentation	Guidance	Document(s)	Dated Within

1. A procedure describing how public health ethical issues are deliberated and resolved. The procedure must describe: a. Which individuals are responsible for making collaborative decisions about ethical issues. b. How the decisionmakers gather information, including input from affected stakeholders. c. How the decision could be re-evaluated in light of new information. d. How the decision is communicated back to affected stakeholders.	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 departments may wish to be transparent about who participates in this decision-making process. 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. 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. For required element d: To build community trust, it is important that the health department communicate with affected stakeholders about decisions that are made. The process could include, for example, timelines for when stakeholders are informed (e.g., within two weeks of a hearing) or modes of communication (e.g., by posting the decision on the website, or corresponding in writing with the affected stakeholders).	1 procedure	5 years
2. Resolution or prevention of the occurrence of an ethical issue using the procedure provided in Required Documentation 1.	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	1 example or a narrative of an example	5 years

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.	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 scare 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.		

Measure 10.3.2 A: Communicate with the governing entity routinely and on an as-needed basis.
Foundational Capability Measure

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	Guidance	Document(s)	Dated Within
1. Working relationship between the health department and its	The intent of this measure is to describe the working relationship between the health department and its governing entity or entities. If a health department has multiple governing entities (e.g., one for advisory purposes and another that sets policy), the narrative will reflect the methods and frequency of communication for each entity (element	Narrative description	Describe the current working

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<td>governing entity or entities. The narrative must include:

a. A description of the methods and frequency of regular communications between the health department and its governing entity. If the health department has multiple governing entities, the description must address each.
b. A description of how the health department communicates with its governing entity outside of its regular communications.
c. A description of how the health department ensures that the governing entity has accurate and relevant information to inform its decision making.
d. A description of how the health department shares information discussed by the governing entity with all levels of health department staff.</td>
<td>a) and the working relationships with each of the governing entities, as appropriate for each of the other required elements (b – d).

For required element a:
Methods could include, for example, meetings or correspondence (e.g. email updates, newsletters specific to the governing entity, reports developed for the governing entity, etc.). Frequency could include, for example, both the regular schedule of meetings as well as frequency of regular written communications.

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

For required element c:
The intent of this requirement is that the health department describe their process for providing accurate (i.e., science-based, utilizing the most current data available) and relevant (i.e., applicable to the community served) information to encourage the opinions, positions, and decisions of the governing entity. Information shared could include, for example, routine information sharing on the health department’s performance management system, strategic plan progress, community health assessment findings, community health improvement plan development and progress, workforce needs, and other operational and finance updates. This could also include keeping the governing entity informed of emerging issues, current or proposed policies, and their implications on public health, health indicators, health equity and disparities, disease outbreaks, environmental health hazards, etc. The description could also include, for example, how the health department asks the governing entity about their information needs.

For required element d:
The intent of this requirement is to foster awareness among 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.</td>
<td></td>
<td>relationship</td>
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	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.		

Measure 10.3.3 A: Access and use legal services in planning, implementing, and enforcing public health initiatives.
Foundational Capability Measure

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

Required Documentation	Guidance	Document(s)	Dated Within
1. Engagement with legal counsel. At least one example must describe a situation where receiving **timely** legal counsel was important. If the health department has not consulted with legal counsel in the past 5 years, it must provide a description of the current process for requesting legal counsel.	The intent of this requirement is for the health department to demonstrate how it has consulted or otherwise engaged legal counsel. Engagement with legal counsel could be demonstrated, for example, through the review of current and/or proposed laws or policies either for their implications to the health department or public health practice. More advanced methods of legislative review of policies or laws could consider more formal approaches to public health legal epidemiology by systematically reviewing laws or policies to understand the features of the laws. Other examples could demonstrate consulting with the health department's legal counsel for review or advice on agreements with external parties (e.g., contracts, MOUs/MAAs, etc.) or negotiations. One of the examples will demonstrate how the health department attained timely legal counsel to allow for a response by a set deadline (e.g., a regulation that states the health department must respond to complaints within a set number of days). **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.	2 examples or narratives of examples	5 years