



**Standards & Measures – Version 2022  
Supplemental Guidance for Military  
Installation Departments of Public Health  
*Initial Accreditation***

Adopted November 2023



“This publication was developed under the direction of the Defense Centers for Public Health–Aberdeen (DCPH-A), Defense Health Agency (DHA) Public Health, and as a result of collaboration between DCPH-A and the Public Health Accreditation Board (PHAB), to provide supplemental guidance to the national *PHAB Standards & Measures for Initial Accreditation, Version 2022* to reflect military terminology, operations, and scope of practice within the installation departments of public health serving Army locations (Contract # W81K0422D0018). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Defense, the Defense Health Agency, the Department of the Army, or the U.S. Government. The mention of any non-federal entity and/or its products is for informational purposes only, and is not to be construed or interpreted, in any manner, as federal endorsement of that non-federal entity or its products.”

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## Introduction

The **Public Health Accreditation Board (PHAB) Standards & Measures for Initial Accreditation, Version 2022**, referred to as “**The Standards**,” serves as the official standards, measures, required documentation, and guidance for national public health department accreditation. It serves as a set of standards and measures applicable to Tribal, state, local and Military Installation Departments of Public Health. Standards are the required level of achievement that a health department is expected to meet. Measures provide a way of evaluating whether the standard has been met. Required documentation is the documentation that is necessary to demonstrate that a health department conforms to a measure. All of the standards are the same for Tribal, state, local and Military Installation Departments of Public Health. The term “health department,” as used here and in **The Standards**, refers to the Military Installation Department of Public Health, and these two terms may be used interchangeably.

This **Supplemental Guidance for Military Installation Department of Public Health Initial Accreditation, referred to as “The Supplemental Guidance”** has been customized for Military Installation Departments of Public Health that have regulatory responsibility for public health services at the installation level (Army Regulation (AR) 40–5, revision dated May 12, 2020; Department of the Army Pamphlet (DA PAM) 40–11, 18 May 2020).

**The scope of *The Supplemental Guidance* at this time, and until otherwise amended, is for those Military Installation Departments of Public Health at Medical Treatment Facilities (MTFs) at Army locations and that are named in U.S. Army Medical Command Operations Order (OPORD) 20-09, published 4 NOV 2019.**

**The Supplemental Guidance** does **not** apply to Military Installation Departments of Public Health in Defense Health Agency (DHA) Medical Treatment Facilities (MTFs) on U.S. Navy-, U.S. Marine Corps, U.S. Air Force-, or U.S. Space Force-led installations unless directed by DHA policy or authority. No such authority or policy is in place at the time of this document’s publication, and **The Supplemental Guidance** provided here does not take into account details of installation public health delivery at these services’ installations. Following the release of **The Standards** in February 2022, the Public Health Accreditation Board (PHAB) engaged with the Defense Centers for Public Health–Aberdeen (DCPH-A) to develop supplemental guidance tailored to support Military Installation Departments of Public Health starting in September 2022. Together, PHAB and the DCPH-A reviewed **The Standards** to further develop clarifying guidance and examples reflective of public health programs, services, functions, and operations, as well as examples from within a Military Installation Department of Public Health context. In addition, the guidance within **The Supplemental Guidance** was informed by learnings from the previous experiences of accredited Military Installation Departments of Public Health or those in the process of achieving initial accreditation. It is important to note that as of September 30, 2022, all Military Installation Departments of Public Health, and the MTFs in which they are embedded, moved under the authority, direction, and control of the DHA such that no installation department of public health is affiliated directly with only one military service department (i.e., the term “Army installation department of public health” is now outdated).

**This Supplemental Guidance** provides guidance specific to Military Installation Departments of Public Health preparing for accreditation to aid in their selection of appropriate documentation demonstrating evidence of the Military Installation Department of Public Health’s conformity with requirements. The guidance is designed to support accreditation coordinators and teams, as well as those providing consultation or technical assistance to Military Installation Departments of Public Health. It also guides PHAB’s site visit teams in their review of documentation submitted by applicants to determine whether conformity with a measure has been demonstrated.

Unless otherwise stated, all references to Military Installation Departments of Public Health in this document refer to the entity that is responsible for local, installation public health services. Although most of these entities will be using the Military Installation Department of Public Health nomenclature, the actual name may vary for some locations due to local considerations and scope of services (e.g., multiple installations may be included in the department name, or the installation may be a joint base with the department named accordingly). Activities related to military field public health services in an operational (deployed)

environment are **excluded** for the purposes of public health department accreditation. Further, the activities of Veterinary Services, which may be part of the Defense Public Health Enterprise, are not reviewed as part of PHAB's accreditation review although an installation veterinary services clinic may be included as a partner within Military Installation Departments of Public Health's examples or documents. Users of **The Supplemental Guidance** are encouraged to place this document side-by-side with **The Standards** so as to appropriately apply the supplemental guidance in their preparation for initial accreditation and the selection of documents.

## Overarching Principles

There are a few overarching principles to keep in mind, when using this **Supplemental Guidance**.

- There is **no change** in the accreditation requirements set forth in **The Standards, unless explicitly stated**. Any differences in requirements specific to Military Installation Departments of Public Health are indicated in the far-left column in **bold red font**.
- There is **no change** in the PHAB accreditation review process, as set forth in **PHAB's Policy for National Public Health Department Initial Accreditation**.
- PHAB is **not** prescriptive about the use of specific terminology which varies by jurisdiction. While the Standards & Measures may use the terms, "strategies," "risk communication," or "inequities," the specific terms used by the jurisdiction might be different. For example, "strategies" versus "activities," "risk communication" versus "emergency communications," or "inequities" versus "root causes of disparities." Instead, PHAB's review focuses on meeting the intent of requirements. The Documentation Form may be used in these instances to clarify the relationship if in doubt about the specific terminology used.
- In many cases, the documentation guidance in **The Standards** remains the same. The documentation guidance that is being provided should be used to *supplement* (rather than to "supplant" or replace requirements) and should be used as clarification of PHAB's expectations in the context of military public health practice. *Only* documentation guidance that is unique to Military Installation Departments of Public Health has been provided in this document.
- If the user of this document experiences difficulty in understanding what the measure is requiring, Military Installation Departments of Public Health are encouraged to seek technical assistance and guidance by—
  - Consulting the Defense Health Agency's Public Health Accreditation Program Management Team as a resource providing support on a wide variety of topics to help departments conform to a measure, including, but not limited to, strategic planning, community health assessment and improvement planning, partnerships, public health policy, surveillance, epidemiology, and others;
  - Contacting PHAB's Accreditation Specialists for specific guidance regarding measure or requirement interpretation or questions about the accreditation process, or about technical aspects, such as acceptable documentation (e.g., scope of authority) or file formats; and/or
  - Directing general questions to [Askphab@phaboard.org](mailto:Askphab@phaboard.org).

## Documentation

### How to use *The Supplemental Guidance*

Military Installation Departments of Public Health are encouraged to place *The Supplemental Guidance* side-by-side with *The Standards* when considering appropriate documentation to demonstrate conformity with the requirements. For example, the Military Installation Department of Public Health might read the requirements within Measure 1.1.1, required element a, “A list of participating partners involved in the Community Health Assessment (CHA) process” and refer to guidance in *The Supplemental Guidance* to consider each of the sub-bullets (“i. At least 2 organizations that might represent sectors other than governmental public health”). The Military Installation Department of Public Health is encouraged to read the guidance provided for all health departments in *The Standards* and also read the supplemental guidance which offers that in a military context, partners might include: community coalitions or collaboratives (e.g., Commander’s Ready and Resilient Councils (CR2Cs or CR2C Facilitator), installation/garrison assets such as Morale, Welfare, and Recreation (MWR); Army Community Service (ACS); Family Advocacy Program (FAP); Army Substance Abuse Program (ASAP); Directorate of Emergency Services (DES); Child and Youth Services (CYS); safety; mission/tactical assets such as brigades, battalions, companies, public affairs office, headquarters; or medical assets, such as nursing, behavioral health, or clinical operations.”

In some instances, no additional guidance is provided within *The Supplemental Guidance*, beyond the guidance already outlined in *The Standards*. If there is no supplemental guidance, the Military Installation Department of Public Health must follow the guidance provided within *The Standards*, as applicable to all health departments. For example, the guidance related to the implementation of a community health improvement plan (CHIP) strategy or activity in Measure 5.2.3 A, Required Documentation 1, is the same as provided in *The Standards* (no supplemental guidance is provided within the military context) and this requirement has been omitted from *The Supplemental Guidance*.

In other instances, *The Supplemental Guidance* indicates where there is a difference in the requirements. As noted above, any differences in requirements that pertain to Military Installation Departments of Public Health, are indicated in the far-left column in **bold red font**. While there are very few instances in which the requirements differ, *The Standards* were extensively reviewed considering their appropriateness within a military public health context and include accommodations reflective of those key functions and operations. These differences do not reflect a different level of expected achievement (i.e., a “higher bar” or “lower bar” of achievement). For example, 7.1.1 allows flexibility to use the Documentation Form to indicate the Military Installation Department of Public Health’s role in engaging with healthcare delivery system partners to assess access to healthcare services. As reflected below, the difference in requirements is reflected in **bold red font** in the far-left column.

<p><b>Measure 7.1.1 A</b> <b>Engage with healthcare delivery system partners to assess access to healthcare services.</b></p> <p><i>If the Military Installation Department of Public Health’s role is not clear from the assessment, the Documentation Form may be used to indicate the Military Installation Department of Public Health’s role (as a participant or contributor) or how the Military Installation Department of Public Health reviewed or considered the results of the assessment for each required element, as appropriate.</i></p>	<p>In this example for Measure 7.1.1 A, the difference in requirements is reflected in <b>bold red font</b> in the far-left column.</p>
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## Nomenclature

The public health accreditation standards, measures, and guidance for documentation apply to all Military Installation Departments of Public Health at Army locations named in U.S. Army Medical Command Operations Order (MEDCOM OPORD) 20-09, published 4 November 2019, which vary in size, organizational structure, scope of authority, resources, population served, governance, and geographic region. “Military Installation Departments of Public Health,” as the term used throughout, refers to the departments located at the installation (“installation-level”).

## Population Served

The population served by the Military Installation Departments of Public Health includes, at a minimum, all beneficiaries enrolled to the installation MTF (e.g., active-duty military personnel, their families; and retirees, when applicable), the DoD Civilian workforce assigned to the installation (for occupational health purposes only), and the military units assigned to the installation.

## Governance and Advisory Board(s)

PHAB defines an “advisory board” as, one or more entities that serve in an advisory role to provide guidance on decision making about overall health department operations or public health in the jurisdiction. These entities may be legally mandated (i.e., required by state or local code) (Public Health Accreditation Board. *Standards & Measures for Initial Accreditation, Version 2022*. Alexandria, VA. February 2022). The term “commander,” as it pertains to the governance of Military Installation Departments of Public Health, is specific to the commander to whom the chief of the Military Installation Department of Public Health reports (MTF Commander, or another designated Commander, for example), unless otherwise specified. For Military Installation Departments of Public Health, advisory boards may refer to the MTF command team, for example.

## Authorship and Evidence of Authenticity

PHAB does not intend to prescribe how a Military Installation Department of Public Health meets *The Standards*. The department is expected to ensure that the standards are met for the population that it serves, which at minimum must include the population served, as specified above. The focus of the standards, measures, and required documentation is that the Military Installation Department of Public Health ensures the provision of the required services and activities to that population, irrespective of how those services and activities are delivered (that is, through which organizational structure or arrangement). A Military Installation Department of Public Health may use the documentation of one or more partners to demonstrate conformance to a measure. All documents must, however, show evidence of authenticity. That is, the document must include a logo, signature, email address, or other evidence to demonstrate authorship or adoption.

## Selection of Documentation

Military Installation Departments of Public Health should select documentation carefully to ensure that it accurately reflects the department, how it operates, what it provides, and how well it performs. Military Installation Departments of Public Health should refer to [The Standards & Measures for Initial Accreditation, Version 2022](#), “Requirements for All Documentation,” for requirements and guidelines regarding documentation selection.

A Military Installation Department of Public Health may enter into formal agreements, contracts, or partnerships with other organizations or agencies to provide services; if so, *The Standards* may indicate that formal agreements are required. If a particular required documentation does not specify that a formal agreement is needed, the Documentation Form may be used to indicate how the documents are relevant or used by the Military Installation Department of Public Health.

Documentation may have been developed by another entity; if so, it must currently be utilized by the Military Installation Department of Public Health under review. The purpose of PHAB’s documentation review is to confirm that materials exist and are in use by the Military Installation Department of Public Health under review, regardless of the material’s origin. Documentation, therefore, may be products of other entities.

Documentation may be developed by—

- Military Installation Department of Public Health staff;
- Community partnerships or collaborations on- or off-post;
- Department of Defense (DoD);

- Defense Health Agency (DHA), including, but not limited to, DHA Public Health or the Defense Centers for Public Health–Aberdeen (DCPH-A), formerly the U.S. Army Public Health Center (APHC);
- U.S. Military Departments (e.g., Department of the Army (DA));
- Other U.S. Military organizations (e.g., Public Health Activity, Medical Readiness Command (MRC));
- Partners (e.g., not-for-profits and academic institutions); or
- Contracted service providers.

The accountability for meeting the measures rests with the Military Installation Department of Public Health under accreditation review. The department must provide evidence of meeting the measure, even if such documentation is produced by another agency, component, unit, or a partner organization. It is advisable for the department to include an explanation using the required Documentation Forms to describe use of documentation developed by others.

Instances in which the Military Installation Department of Public Health might use or rely upon documentation developed by others include, for example:

- The Military Installation Department of Public Health, as part of a larger organization with higher chains of command, may utilize the policies, procedures, or functions of those organizations and commands.
  - For example, the Military Installation Department of Public Health may utilize the human resources system of the organization of which it is a part or that of another identified support agency. In this case, the documentation for “human resource policy and procedures manual or individual policies” would be the policies and procedures of the applicable organization or support agency.
- The Military Installation Department of Public Health shares functions or services with other military or partner agencies.
  - For example, environmental health services are sometimes provided by or supported by another installation/garrison entity, military agency, or a local agency. A number of public health accreditation standards and measures include or address environmental health. A Military Installation Department of Public Health’s documentation should include examples from environmental health; these examples may be documents produced by that other agency.
- The Military Installation Department of Public Health may receive other military support for provision of public health functions.
  - For example, if an MRC, other Military Installation Department(s) of Public Health, or other military entity provides support for a public health function such as an outbreak investigation, the applicant Military Installation Department of Public Health must still provide documentation that the function is being performed. The applicant Military Installation Department of Public Health cannot dismiss its accountability for meeting the measure, even if a contractor, another military organization, higher headquarters, or another Military Installation Department of Public Health is responsible for performing the function on the department’s behalf.

## Documentation Not Approved for Electronic Submission

Within the military and governmental public health contexts, certain file types may contain confidential information that **CANNOT** be uploaded to PHAB’s electronic information technology system (e-PHAB). Instead of being uploaded, these files should be provided via screenshare during virtual accreditation site visits or in-person during the onsite accreditation site visit with appropriate redactions. Additional time will be allotted within the accreditation site visit for a review of these materials.

The following types of documents may be used as documentation but **CANNOT** be uploaded into e-PHAB:

- **Documents containing personally identifiable information (PII) or protected health information (PHI).** PII or PHI must be redacted from all accreditation documentation.
- **Any document containing financial or personnel system data.**



- This includes audits, budgets, Program Objective Memorandum (POM) submissions, work plans, statements of operations, requirements planning tools and/or any data or reports from financial, timekeeping, or equipment systems including, but not limited to, Defense Medical Human Resource System internet (DMHRSi), Automated Time Attendance and Production System (ATAAPS), General Fund Enterprise Business System (GFEBs), Medical Expense and Performance Reporting System (MEPRS), or Defense Medical Logistics Standard Support (DMLSS).
- **Controlled Unclassified Information (CUI) documents and other potential sensitive documents** such as, but not limited to, Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), contracts, organizational wiring diagrams containing the names of individuals, and budgetary or financial documents.
  - If only position titles (rather than individual names) are listed, then this document can be uploaded in e-PHAB.
- **E-mails or distribution lists** that have not been approved for inclusion in e-PHAB by the sender or a recipient.
- **Other manpower and personnel documents**, including personnel performance evaluations containing the names of individuals.
- **Full versions of installation, or MTF, or other emergency response plans containing the names of individuals or other sensitive information as determined by the MTF, installation/garrison, and/or applicable emergency manager.**

While the documents listed here cannot be shared electronically, a brief description of these documents or systems should be provided within required Documentation Forms (e.g., coversheets). The Documentation Forms provided by PHAB contain fields to provide the name of the document with a brief description of its contents and how it relates to demonstrating conformity with documentation requirements.

If the Military Installation Department of Public Health is unsure of its ability to submit and/or share particular documentation to/with the PHAB, the department should consult the Defense Health Agency's Public Health Accreditation Program Management Team or the applicable Security Office.

**Any information that is deemed "classified" for reasons of national security shall not be used as accreditation documentation at all.**

## Synchronization with Health Care Accreditation Activities

Military Installation Departments of Public Health may benefit from a number of services (such as Human Resources, Resource Management, Public Affairs, and/or Emergency Management) performed through a relationship with another organization located, including, but not limited to, the installation's Medical Treatment Facility (MTF). While some of these services may also pertain to the MTF's healthcare accreditation requirements (e.g., The Joint Commission standards), if applicable, it is essential to clearly identify that these activities are also available to the Military Installation Department of Public Health in its role as the "installation department of public health" or "installation public health authority". There may be instances where documentation requirements for healthcare accreditation and public health accreditation are similar. To help applicant Military Installation Departments of Public Health to identify where documentation requirements may be the same or similar to healthcare accreditation, the following guidance is indicated with an asterisk (\*) and noted within those measures for which this could apply:

“\*Note: Documentation for this requirement may be similar in intent or the same as that used for MTF healthcare accreditation. If applicable, coordinate with appropriate entities within the MTF to identify whether the healthcare accreditation documentation may also apply to and/or support this public health department accreditation requirement. It should be noted, however, that documentation assessed as acceptable by another accrediting body against its standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.”

## Acronyms & Glossary of Terms

*The Supplemental Guidance* is accompanied by a sourced, military-specific (Army-centric) [Acronyms & Glossary of Terms](#) (released in February 2019) with a list of acronyms updated in 2023.

## 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.

##### Foundational Capability Measure

##### Measure 1.1.1 A Develop a community health assessment.

##### Required Documentation 1

##### **For required element a:**

The development of a community health assessment includes the participation of partners representing various sectors of the community, which could include those from the installation and/or local communities neighboring the installation, for example, education, social services, health, transportation, or law enforcement. Partners could also include those represented on community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs)); public affairs offices from any command; installation/garrison assets such as Morale, Welfare, and Recreation (MWR); Army Community Service (ACS); Family Advocacy Program (FAP); Army Substance Abuse Program (ASAP); Department of Emergency Services (DES); Child and Youth Services (CYS); safety; mission/tactical assets such as brigades, battalions, companies, relevant headquarters; or medical assets such as nursing, behavioral health, or clinical operations.

The partnership will include community members directly or include organizations representing those populations who are disproportionately affected by conditions that contribute to poorer health outcomes or for whom systems of care are not appropriately designed. For Military Installation Departments of Public Health, individuals or organizations representing populations who have lived experiences with, or are disproportionately affected by, conditions that contribute to poorer health outcomes could include, for example, junior enlisted service members (those aged 18–24 within lower enlisted ranks), Better Opportunities for Single Soldiers (BOSS), those served by the Exceptional Family Member Program (EFMP), individuals who identify as LGBTQ+, communities of color, individuals with special needs such as those with visual and/or hearing impairments, or individuals with disabilities. (If it is unclear from the documentation who the participants are, the Documentation Form may so indicate—for example, to clarify who community member representatives are, or which partners are representing populations disproportionately affected by poorer health outcomes).

##### **For required element b:**

The current adopted model for community health assessment and improvement planning at Military Installation Departments of Public Health at Army locations is Mobilizing for Action through Planning and Partnerships (MAPP; National Association of County and City Health Officials (NACCHO)), as a nationally recognized model.

##### **For required element c:**

Primary data are data for which collection is conducted, contracted, or overseen by the Military Installation Department of Public Health or community health assessment partnership. Primary data could include, for example, local surveys (for example, surveys of high school students and/or parents), focus groups, town halls, sensing sessions, or key informant interview (for example, to discuss unit health issues), or other data that the Military Installation Department of Public Health collects to better understand contributing factors or elements of secondary data sets.

	<p>Secondary data sources might include service-specific, Department of Defense (DoD), other Federal, state, and local data. If the data collection is conducted, contracted, or overseen (i.e., the data collection instruments are designed) by the Military Installation Department of Public Health or the community health assessment partnership as a whole, it would <b>not</b> meet the intent of the element. However, data collected by a single partner of the collaborative (e.g., Electronic Health Record (EHR) data from the Medical Treatment Facility (MTF) that is part of the community health assessment partnership) would be appropriate. Specific secondary data sources could include, for example, data contributed by installation/garrison entities such as the Army Community Service (ACS), Directorate of Emergency Services (DES), Army Substance Abuse Program (ASAP), Morale, Welfare, and Recreation (MWR); medical entities such as Medical Treatment Facilities (MTFs), other hospitals or clinics, and health care providers; local schools and academic institutions; other governmental agencies or departments (e.g., public health, recreation, public safety, etc.); or not-for-profit, non-governmental organizations in communities surrounding the installation. In addition to secondary data sources listed, Military Installation Departments of Public Health might also consider, for example, the Azimuth Check (formerly known as the Global Assessment Tool (GAT)) or the Periodic Health Assessment (PHA) data; <i>Health of the Force</i> reports; regular epidemiological reports; the Health Care Survey of DoD Beneficiaries, Behavioral Risk Factor Surveillance Survey (BRFSS) or Youth Risk Behavior Surveillance (YRBSS); County Health Rankings; or Defense Centers for Public Health (DCPH) reports.</p> <p><b>For required element d:</b> In addition to ethnic and racial composition and languages spoken, the description of the demographics of the population of the jurisdiction served by the Military Installation Department of Public Health may also include, for example, gender, rank, age, income, disabilities, travel time to work or to health care, households with only one vehicle, educational attainment, home ownership, spouse employment status, immigration status, dependent, service member, retiree, and/or civilian personnel status, sexual orientation or LGBTQ+ status, etc.</p> <p><b>For required element e:</b> The description of health challenges experienced by the population served by the Military Installation Department of Public Health, as based on primary or secondary data (from required element c) in terms of health status and health behaviors, might consider, for example, an analysis comparing health status and health behaviors by age, gender, service member military occupational specialties (MOS), living on- or off-post, military rank, or other factors to examine disparities between subpopulations or other demographic variables.</p> <p><b>For required element f:</b> Within its description of inequities, the Military Installation Department of Public Health might consider factors such as housing conditions or living arrangements (e.g., in barracks compared to personal housing, or on-installation vs. off-installation housing), transportation (e.g., one-car households), or other social determinants of health or unique characteristics of the installation community that impact health status.</p> <p><b>For required element g:</b> Assets and resources that can be mobilized and employed to address health issues, may include, for example, Soldier Family Readiness Groups (SFRG), spouses' clubs or other peer groups for social connections and cohesion, as well as Morale, Welfare, and Recreation (MWR), community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs)), Army Community Service (ACS), Armed Forces Wellness Centers (AFWCs/AWCs; formerly known as Army Wellness Centers), or other assets and resources.</p>
<b>Measure 1.1.2 A</b>	<b>Required Documentation 1:</b>

<p><b>Ensure the community health assessment is available and accessible to organizations and the general public.</b></p>	<p>In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate sharing key findings and the full community assessment with others (including organizations who are <b>not</b> members of the community health assessment partnership), such as community coalitions or collaboratives (e.g., Commander's Ready and Resilient Council (CR2C) members or CR2C Board of Directors); installation/garrison assets such as Morale, Welfare, and Recreation (MWR); Army Community Service (ACS); Family Advocacy Program (FAP); Army Substance Abuse Prevention (ASAP); emergency services; Child and Youth Services (CYS); safety; mission assets such as brigades, battalions, companies, public affairs office, CR2C Facilitator, integrated prevention workforce, headquarters; or medical assets such as nursing, behavioral health, clinical operations; as well as partners representing various sectors, such as education, social services, health care, transportation, and law enforcement provided by the installation and/or local communities neighboring the installation.</p> <p>In addition to the methods described within <i>The Standards</i>, Military Installation Departments of Public Health could also demonstrate active sharing through Executive Summaries (EXSUMs), Information Papers (IPs), reports or interim progress reports, briefings, minutes of briefings presented, or other communications.</p>
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<p align="center"><b>STANDARD 1.2</b></p> <p align="center"><b>Collect and share data that provide information on conditions of public health importance and on the health status of the population.</b></p>	
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 1.2.1 A</b></p> <p><b>Collect non-surveillance population health data.</b></p>	<p>Primary data are data for which collection is conducted, contracted, or overseen by the Military Installation Department of Public Health. Primary population health data could be collected, for example, using Defense Health Agency (DHA), Department of Defense (DoD), service-specific, national, statewide, or local data collection tools. The data may also be standardized in that the same tool was used with all respondents, such as a local survey or sensing sessions, town halls, or key informant interviews distributed to or conducted with respondents in the community.</p> <p>If the Military Installation Department of Public Health provides funding for data collection, has a formal agreement for data collection, or works with another entity (e.g., an academic institution, DHA Public Health, state health department, or other organization), community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs)), an umbrella agency, or another division of the umbrella agency (e.g., the Medical Treatment Facility (MTF)) on the design or implementation of the data collection instrument, the data collected would be considered primary and would meet the intent of this requirement.</p> <p>If the Military Installation Department of Public Health's role in data collection is not evident, it could be clarified in the Documentation Form.</p> <p>The data collection is intended to enhance the knowledge and understanding of the population served by the Military Installation Department of Public Health. For example, data may pertain to social conditions that have an impact on the health of the population served, such as spousal under- or unemployment issues; lack of accessible facilities for physical activity; housing; transportation; and lack of access to fresh foods.</p> <p>While surveillance data, program evaluation, and customer satisfaction do <b>not</b> meet the intent of the requirements, the Military Installation Department of Public Health might consider use of primary quantitative and qualitative data collection instruments used as part of the community health assessment or community health improvement plan, or other processes.</p>

	<p>Surveys can be used to collect both quantitative data (e.g., responses to multiple choice questions, true or false questions, questions with a Likert scale or other form of rating, or questions that ask for a numerical answer) and qualitative data (e.g., open-ended questions). If the data collection instrument includes both quantitative and qualitative data, the same instrument (element a) can be used as one of the examples required for both Required Documentation 1 and Required Documentation 2. If the same instrument is used, the Documentation Form will indicate the qualitative questions in the instrument.</p> <p><b><u>Required Documentation 1:</u></b>  <b>For required element a:</b>  In addition to the examples provided within <i>The Standards</i> or above guidance, a Military Installation Department of Public Health could also consider primary <u>quantitative</u> data collection instruments used as part of the community health assessment process, or other surveys, such as the Military Nutritional Environmental Assessment Tool (mNEAT), which uses numerical data to assign a ranking when performing an environmental scan of existing conditions and policies across fast food chains, dining facilities, vending options, etc.; the installation’s Community Strengths and Themes Assessment (CSTA) survey to understand the health and wellness needs of special populations such as LGBTQ or Single Soldiers; or other closed-ended surveys or quantitative data collection instruments designed to gain a deeper understanding of the health issues in the community.</p> <p><b>For required element b:</b>  For Military Installation Departments of Public Health, evidence that the instrument was used to collect primary quantitative data about health status and factors contributing to health status might include, for example, Executive Summaries (EXSUMs), Information Papers (IPs), reports, briefings, minutes of briefings presented, or other communications of the data results.</p> <p><b><u>Required Documentation 2:</u></b>  In addition to the examples provided within <i>The Standards</i> , primary <u>qualitative</u> data collection might include results of, for example, focus groups or sensing sessions (e.g., to explore quality of life or factors contributing to higher health risks such as injuries, nutrition, substance use, or behavioral health concerns or other topics); climate assessments; or qualitative data collected as part of the community health assessment process, such as the Mobilizing for Action through Planning and Partnerships (MAPP; National Association of County and City Health Officials (NACCHO)) Forces of Change (FoC) Assessment, Community Partners Assessment (CPA), or Community Context Assessment (CCA), etc.</p> <p>For Military Installation Departments of Health, data collected directly from groups or individuals who are at higher health risk might include, for example, junior enlisted (those aged 18–24 within lower enlisted ranks), Better Opportunities for Single Soldiers (BOSS), those served by the Exceptional Family Member Program (EFMP), individuals who identify as LGBTQ+, communities of color, etc.</p>
<p><b>Foundational Capability Measure</b>  <b>Measure 1.2.2 T/L</b>  <b>Participate in data sharing with other entities.</b></p>	<p><b><u>Required Documentation 1:</u></b>  Beyond the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health might demonstrate providing, receiving, or exchanging data with the Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), a Medical Readiness Command (MRC), or a Defense Health Agency (DHA) market/network, as well as neighboring military, local, or state health department(s). The Installation Department of Health could demonstrate sharing or receiving record-level data through the use of data systems such as those pertaining to environmental health, worksite air quality, infectious disease reporting, water sample test results (e.g., Defense Occupational and Environmental Health Readiness System (DOEHRS), Disease Reporting System internet (DRSi)), or other systems.</p>

## STANDARD 1.3

### Analyze public health data, share findings, and use results to improve population health.

#### Foundational Capability Measure

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

The data could be analyzed by the Military Installation Department of Public Health or another entity, so long as it includes data specific to the population. The Military Installation Department of Public Health might consider, for example, the community health assessment as a source of data specific to the population served or to a subset of the jurisdiction's population, such as quantitative population health or key health indicators; or community survey data collected.

In addition to data sources listed in the guidance, the Military Installation Department of Public Health might consider data collected by the Armed Forces Health Surveillance Division (AFHSD), service medical departments (e.g., U.S. Army Medical Command (MEDCOM)), Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), advocacy and service agencies (e.g., Army Family Action Plan (AFAP), Family Advocacy Program (FAP)), the state health department, an Armed Forces Wellness Center (AFWC/AWC), Unit Risk Inventory (URI) survey data, health care or dental care data, *Health of the Force* reports or *Health of the Force* Online, or other data.

Other data sources might include epidemiologic data, vital statistics, workplace injury or disease investigation results, cluster identification or investigation results, outbreak investigation results, environmental and occupational hazard data, outbreak After Action Reports (AARs), analysis of hospital data, analysis of not-for-profit organizations' data (such as poison control center data or child health chart book), health disparities data, environmental data, occupational health data, socioeconomic data, stratified health disparities data, and community health indicator data. Other examples include results of an investigation of a foodborne disease outbreak, noise hazards in the workplace, or trends of reported infectious diseases analyzed within the past 5 years.

Program evaluation, customer satisfaction surveys, or employee satisfaction surveys do **not** meet the intent of this requirement.

#### **Required Documentation 1:**

##### **For required element a:**

In a military context, comparisons of quantitative data could consider the prevalence of various health conditions between the population served by the installation and other socio-geographic areas, sub-state areas, the state, or national rates or as compared to the population served by another Installation Department of Public Health or Department of Defense (DoD) or Army/other military branch rates. For example, the installation could consider the prevalence of chronic disease rates or incidence of infectious diseases compared with state or national rates or another Installation Department of Public Health. Comparisons could also be made based on socio-economic status or social conditions that have an impact on the health of particular or specific populations served, for example, spouse under- or unemployment, poor housing, lack of transportation, or lack of accessible healthy food facilities. The example could also draw comparisons based on a subset of the jurisdiction's population, which might include individuals who represent high-risk, junior enlisted (those aged 18–24 within lower enlisted ranks, regardless of marital status); Better Opportunities for Single Soldiers (BOSS) participants; those served by the Exceptional Family Member Program (EFMP); individuals who identify as LGBTQ+; communities of color; individuals who are blind, deaf, or hard of hearing; or individuals with disabilities.

##### **For required element b:**

The Military Installation Department of Public Health may use the Documentation Form to indicate the analytic process used. Analysis to understand the relationship between variables may be performed by another entity such as the Defense Centers for Public Health–Aberdeen (DCPH-A), Medical Readiness Command (MRC), state or local health department, or others, such as academic institutions, so long as the data analyzed pertain to the population served by the installation.

	<p><b>For required element c:</b>  In addition to the examples provided within <i>The Standards</i>, drawing conclusions about quantitative data analyzed in the military context might be based on a number of different variables, such as drawing inferences about higher rates of illness or infectious conditions among those living on or off base or in barracks, those with limited transportation as an implication for accessing health care, or causes of differences in immunization rates; or drawing conclusions based on comparisons between Exceptional Family Member Program (EMFP) beneficiaries and non-beneficiaries.</p> <p><b><u>Required Documentation 2:</u></b>  Qualitative data may address, for example, the community’s perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Data collection methods include, for example, sensing sessions, open-ended climate assessments, or qualitative data collected as part of the community health assessment process, such as, the Mobilizing for Action through Planning and Partnerships (MAPP) Forces of Change (FoC) assessment, Community Themes and Strengths Assessment (CTSA), or Community Context Assessment (CCA), etc. The analysis itself can be completed by another entity, such as the Defense Centers for Public Health–Aberdeen (DCPH-Aberdeen)/Defense Health Agency Public Health (DHA Public Health), an academic partner, a Medical Readiness Command (MRC), or a state or local health department.</p> <p><b>For required element b:</b>  In addition to the examples provided within <i>The Standards</i>, conclusions drawn from the analysis of qualitative data might consider, for example, themes that emerged during climate assessments, focus groups, or sensing sessions about the implications of social conditions that have an impact on the health of particular or specific populations served, such as spouse under- or unemployment, poor housing, lack of transportation, or lack of accessible healthy food facilities, or other relationships to make meaning of data.</p>
<p><b>Measure 1.3.2 A</b>  <b>Share and review public health findings with stakeholders and the public.</b></p>	<p><b><u>Required Documentation 1:</u></b>  The Military Installation Department of Public Health could use a variety of methods to present data findings beyond the examples provided in the guidance, such as Executive Summaries (EXSUMs), Information Papers (IPs), reports or interim progress reports, briefings, minutes of briefings presented, or other communications.</p> <p><b>For required element a:</b>  In addition to the examples of sources provided within <i>The Standards</i>, the Installation Department of Public Health might also consider the Armed Forces Health Surveillance Division (AFHSD), service medical departments (e.g., U.S. Army Medical Command (MEDCOM), U.S. Army Medical Center of Excellence (MEDCoE), Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), advocacy and service agencies (e.g., Army Family Action Plan (AFAP), Family Advocacy Program (FAP)), the state health department, an Armed Forces Wellness Center (AFWC/AWC), Unit Risk Inventory (URI) survey data, health care or dental care, <i>Health of the Force</i> reports or <i>Health of the Force</i> Online, or other data to demonstrate an understanding of how multiple factors affect health issues.</p> <p><b>For required element b:</b>  At least some data specific to the population or to a subset of the population might include, for example, individuals who represent high-risk, junior enlisted (those aged 18–24 within lower enlisted ranks); Better Opportunities for Single Soldiers (BOSS) participants; those served by the Exceptional Family Member Program (EFMP); individuals who identify as LGBTQ+; communities of color; individuals who are blind, deaf, or hard of hearing; or individuals with disabilities.</p>

	<p><b>For required element d:</b>  In addition to the examples provided within <i>The Standards</i>, methods to distribute materials to a variety of audiences within a military context might include, for example, bulletins to the community; email distribution to community or on- and off-post community organizations (e.g., spouses' club); postings on the department or installation/garrison website; media releases; meeting minutes documenting distribution of the summaries; fact sheets or Ips; briefings and inserts or flyers; or a dynamic website of data that are updated as they become available. If the distribution is not evident in the example, it may be indicated in the Documentation Form.</p> <p><b>Required Documentation 2:</b>  For Military Installation Departments of Public Health, key data findings could be presented or discussed with external partners, such as those off-post, as well as other departments, units, or agencies at the Medical Treatment Facility (MTF) or on the installation. For example, the Military Installation Department of Public Health could share key data findings with health care providers in the surrounding off-post communities, an off-post or community-wide coalition, or with neighboring local health departments. The Military Installation Department of Public Health could also consider sharing key findings with another department, unit, or agency at the MTF or on the installation, such as junior service members' housing data, which might also have a correlation with binge drinking, drunk driving, or other topics.</p> <p>Examples of documentation include summaries, fact sheets, or Ips of public health data findings; minutes; interim progress reports; or other documentation of briefings to show the presentation, review, and discussion of data analysis.</p> <p>Key findings may be drawn from quantitative or qualitative data (or both) or from primary or secondary sources (or both). Sharing findings with internal health department staff would <b>not</b> meet the intent of this requirement. The examples of presenting or discussing key data findings for this requirement could relate to the examples provided in Measure 1.3.1, Measure 1.3.2 Required Documentation 1, or could demonstrate presenting or discussing different data findings, including those from reports or articles that were not developed by the installation.</p> <p>The Military Installation Department of Public Health may engage with a wide range of external stakeholders about findings, for example, community coalitions or collaboratives (e.g., CR2C members or CR2C Board of Directors), health care providers, units, veterinarians, installation/garrison or mission command teams, community e groups, local schools, labor unions, other stakeholders, partners, or the public served by the Military Installation Department of Public Health. Engagement with the governing entity is defined as the commander to whom the Military Installation Department of Public Health's chief reports that has responsibility for the Military Installation Department of Public Health or advisory board which may refer to the MTF command team, for example.</p>
<p><b>Measure 1.3.3 A</b>  <b>Use data to recommend and inform public health actions.</b></p>	<p><b>Required Documentation 1:</b>  In addition to the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate use of the data to inform program improvements or new or revised policies, progress, services, programs, or interventions designed as part of or with community coalitions or collaboratives (e.g., CR2Cs), Public Health Activity, installation/garrison agencies or command, mission/tactical command teams, Medical Treatment Facility (MTF) partners or command, another agency, or developed within the Military Installation Department of Public Health itself to improve the health of the population.</p>

## 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.

#### Foundational Capability Measure

#### Measure 2.1.1 A Maintain surveillance protocols.

#### **Required Documentation 1:**

In addition to the surveillance system examples provided within *The Standards*, the Military Installation Departments of Public Health might also include the United States Department of Defense's Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), the Defense Occupational and Environmental Health Readiness System (DOEHRS), the Disease Reporting System internet (DRSi), or the Defense Medical Surveillance Site (DMSS). Other surveillance systems might include, for example, the Food and Drug Administration's Adverse Events Reporting System (AERS), the Centers for Disease Control and Prevention's (CDC's) Vaccine Adverse Events Reporting System (VAERS), the National Retail Data Monitor for Public Health Surveillance (NRDM), a state's notifiable disease reporting system, or a chronic disease surveillance system. Environmental health surveillance systems could include, for example, the Environmental Protection Agency's Ambient Air Quality Monitoring System (AQS); water quality, sewage, or lead hazard systems; or other systems.

#### **Required Documentation 2:**

The Military Installation Department of Public Health may maintain its own process(es) or protocol(s) for public health surveillance or rely on those of a higher-level agency or organization. For example, the Military Installation Department of Public Health may use process(es) or protocol(s) developed by a partner or higher-level agency such as the Defense Health Agency (DHA), a Defense Center for Public Health/DHA Public Health, a DHA market/network, Medical Readiness Command (MRC), or the Armed Forces Health Surveillance Division (AFHSD). If the Military Installation Department of Public Health plays any role in a particular required element, the process or protocols will address how the installation performs its role in that element. For example, if the Military Installation Department of Public Health reports data to a surveillance system maintained or operated by another entity, such as disease reporting through the Disease Reporting System internet (DRSi), required element a will describe how the installation reports those data. If the Military Installation Department of Public Health has no role in a particular required element, the process(es) or protocol(s) must address how another agency conducts that element on behalf of the installation.

#### **For required element a:**

The Military Installation Department of Public Health's protocol(s) or process(es) could address multiple methods to report or collect surveillance data, such as through surveillance systems, a designated telephone line (voice or fax), email address(es), or the Military Installation Department of Public Health's website. Reports may be received by an off-duty Military Installation Department of Public Health staff member via cell phone call, the umbrella agency's (e.g., MTF's) staff duty officer, via various processes or procedures, regional or state agreements, regulation, or other arrangements. The Military Installation Department of Public Health defines from whom reports are received.

#### **For required element b:**

In addition to the data quality control measure examples provided within *The Standards*, the Military Installation Department of Public Health's process(es) or protocol(s) may include oversight by a designated contact person at the Military Installation Department of Public Health and/or at a higher-level agency (e.g., regional epidemiologist, Defense Health Agency Public Health (DHA Public Health)/ Defense Centers for Public Health (DCPH)). If performed by another agency on behalf of the Military Installation Department of Public Health, the process or protocol will address what data quality control measures are in place (e.g., who is responsible for checking for duplication, ensuring complete data entry, addressing outliers, cleaning data, etc.) and how this agency(ies) conducts this.

	<p><b>For required element c:</b> For Military Installation Departments of Public Health, analysis to identify deviations from expected trends could be performed by another entity, such as a Defense Centers for Public Health (DCPH), Medical Readiness Command (MRC), DHA market/network, DHA, or state or local health department.</p> <p><b>For required element d:</b> In addition to the examples specified in <i>The Standards</i>, data could be disaggregated by subpopulation considering, for example, health status or health behaviors by on- versus off-post residence, Military Occupational Specialty (MOS), military rank, recent deployment status, or other factors of interest to examine disparities between subpopulations.</p> <p><b>For required element g:</b> The Military Installation Department of Public Health or a higher-level or partner agency determines how the system is tested and the frequency of such testing (both of which are expected to be defined in the processes and/or standard operating procedure(s) (SOPs)). The testing process can include receipt of a sample report by the various elements of the system. For example, the protocol or process might outline methods to test the system’s capabilities to receive surveillance data by internet, fax, email and a designated phone line, or other methods present in the system.</p> <p>Documentation of how other entities perform surveillance could include, for example, a Memorandum of Understanding (MOU), Memorandum of Agreement (MOA), or copy of the regulation, pamphlet, instruction, SOP, or other policy/procedure. If a higher-level or partner agency is carrying out the functions, the military installation department of public health could provide the agency’s or DoD’s surveillance manual or other documentation that describes how functions are performed on behalf of the Military Installation Department of Public Health by that other agency.</p>
<p><b>Measure 2.1.2 A</b> <b>Communicate with surveillance sites.</b></p>	<p><b><u>Required Documentation 1:</u></b> The process to maintain the list of surveillance sites might be in the form of a departmental or other applicable agency’s Standard Operating Procedure (SOP) or policy. The process to maintain updated contact information may be the role of a designated staff member, such as an epidemiology technician, epidemiologist, public health nurse, or other staff member(s). Documentation for this measure should describe, for example, regularly updated and verified lists of sites of those reporting surveillance data to the Military Installation Department of Public Health, such as, but not limited to, Medical Treatment Facilities (MTFs), health care providers, schools, Child and Youth Services (CYS), laboratories, veterinarians, and neighboring local health departments.</p> <p><b><u>Required Documentation 2:</u></b> The intent of this requirement is to demonstrate training provided to surveillance sites, whether the materials were developed by the Military Installation Department of Public Health or others, such as the Defense Health Agency Public Health (DHA Public Health) or a Defense Center for Public Health (DCPH). Trainings or meetings may address general surveillance requirements or disease-/condition-specific requirements.</p> <p>Trainings or meetings could be delivered in person, online, via webinars or other virtual collaborations, or by more passive methods to share information, for example, pre-recorded videos, information papers (Ips), or email notifications.</p> <p><b>For required element b:</b></p>

	<p>Reportable diseases/conditions in military settings are specified in the <i>Armed Forces Reportable Medical Events Guidelines and Case Definitions</i> document and in laws or rules from the applicable state. The training will include what reportable diseases/conditions that surveillance sites (e.g., health care providers, laboratories, Medical Treatment Facilities (MTFs), Child and Youth Services (CYS), and others) are required to report to the Military Installation Department of Public health according to both the Armed Forces rules and state laws/rules.</p> <p><b>For required element c:</b> Timeframes for reporting refer to when the surveillance site is required to report to the Military Installation Department of Public Health, rather than the health department’s timeframe of reporting to the state health department, Defense Centers for Public Health (DCPH), Defense Health Agency (DHA), Centers for Disease Control and Prevention (CDC), or others. The timeframes for reporting may vary based on the reportable disease/condition case (e.g., surveillance sites may be required to report a suspected or laboratory-confirmed diagnosis immediately, within 24 hours, or the next business day, depending on the type of reportable disease/condition).</p> <p><b>Documentation Examples:</b> Documentation could be, for example, training or meeting materials (such as training agendas, meeting minutes or slides/handouts), pre-recorded videos, online training modules, emails, EXSUMs, or reports.</p> <p><b>Required Documentation 3:</b> In addition to the examples provided within <i>The Standards</i>, surveillance data received into a system from a surveillance site could include, for example, reports of influenza cases, animals with confirmed rabies, or environmental health data. Documentation could include, for example, screenshots of data received in the Electronic Surveillance System for Early Notification of Community Based Epidemics (ESSENCE), the Defense Occupational and Environmental Health Readiness System (DOEHRS), the Disease Reporting System internet (DRSi), or the Defense Medical Surveillance Site (DMSS).</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 2.1.3 A</b> <b>Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.</b></p> <p><b>Required Documentation 1.</b> <b>Additional required element c. For Military Installation</b></p>	<p><b>Required Documentation 1:</b> <b>For required element a:</b> In addition to the guidance in <i>The Standards</i>, the policy or procedure could, for example, address how a Military Installation Department of Public Health accesses epidemiology resources from regional military assets or Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health). This may be documented via a service-specific regulation, Medical Treatment Facility (MTF), Defense Health Agency (DHA), or similar instruction or Standard Operating Procedure (SOP).</p> <p><b>For required element b:</b> Environmental public health resources to assist Military Installation Departments of Public Health could also include, for example, engineers; environmental protection specialists at the installation, neighboring military, local, or state health departments; regional military organizations; or Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health).</p> <p><b>For required element c:</b> Occupational health resources could include, for example, engineers, ergonomists, health physicists, or industrial hygienists. The policy or procedure could specify, for example, how additional resources may be accessed when needed (e.g., workplace air quality issue, workplace mold contamination).</p> <p><b>Required Documentation 2:</b></p>

<p><b>Departments of Public Health, the policy(ies) or procedure(s) must also address occupational health hazards.</b></p>	<p>For <b>each</b> laboratory that the Military Installation Department of Public Health uses, the department must provide documentation that the laboratory is accredited, certified, and licensed appropriately for all the testing that it performs. Examples of documentation include, but are not limited to, Clinical Laboratory Improvement Amendments (CLIA) licenses, state water laboratory certifications, and licenses and certifications for industrial hygiene-related and environmental health laboratories used by the department for testing.</p> <p><b>Required Documentation 3:</b>  Laboratory protocols for packaging and transporting specimens 24/7 for testing during both normal business hours and outside of business hours may be maintained by the Military Installation Department of Public Health laboratory; within the Medical Treatment Facility (MTF); private, contracted laboratories; reference laboratories; or a combination of both internal and external laboratories. Specimens may be packaged and transported for environmental health, occupational health, industrial hygiene, epidemiologic testing, etc. Protocols may vary based on state or regional laboratories, military or civilian laboratories, specimen type, or testing performed.</p>
<p><b>Measure 2.1.4 A</b>  <b>Maintain protocols for investigation of public health issues.</b></p>	<p><b>Required Documentation 1:</b>  <b>For required element b:</b>  In addition to the guidance provided in <i>The Standards</i>, Military Installation Departments of Public Health protocols addressing investigation for noninfectious illness could address, for example, heat illness or lead poisoning.</p> <p><b>For required element c:</b>  In addition to the guidance provided in <i>The Standards</i>, Military Installation Departments of Public Health protocols addressing investigation for noninfectious illness could address, for example, cold weather injuries.</p> <p><b>Required Documentation 2:</b>  Military Installation Departments of Public Health may or may not have different investigation protocols for illness, environmental health issue, or injury, depending on the facility type or setting (e.g., Child and Youth Services (CYS) facility, shop, etc.). If there are different protocols in place based on setting, then the two examples used for this requirement must be from different settings; one protocol must address an infectious illness, and the other cannot address an infectious illness unless infectious illness is the only type of investigation for which the Military Installation Department of Public Health has lead responsibility.</p> <p><b>For required element b:</b>  iii. For Military Installation Departments of Public Health, applicable reporting requirements for reportable conditions may be defined in Standard Operating Procedures (SOPs)/rules/regulations, etc. Applicable reporting requirements may be defined, for example, in the Armed Forces Reportable Medical Events List, or state law, code, rules, or regulations. If reporting requirements for a particular condition or illness are only applicable to one of the entities to which the Military Department of Public Health reports, then this can be noted in the Documentation Form.</p>
<p><b>Measure 2.1.5 A</b>  <b>Maintain protocols for containment and mitigation of public health problems and environmental public health hazards.</b></p>	<p><b>Required Documentation 1:</b>  <b>For required element a:</b>  Documentation may include policy memoranda, Standard Operating Procedure(s) (SOP(s)), disaster/ emergency management plans or annexes.</p> <p><b>For required element b:</b>  Military Installation Departments of Public Health are not required to address exercising legal authority for disease control when thresholds are exceeded.</p>

<p><b>Required Documentation 1:</b>  <b>Required element b is not required for Military Installation Departments of Public Health.</b></p>	<p><b>Required Documentation 2:</b>  The Military Installation Department of Public Health could provide an example of an effort or strategy designed to assist, for example, an on-post neighborhood (e.g., a community that experienced high lead levels due to old pipes, or significant mold growth, or asbestos exposure, due to old housing or lack of or poor maintenance), or a subpopulation (e.g., service members living in barracks that are particularly susceptible to an outbreak).</p> <p>The Military Installation Department of Public Health may or may not be the lead agency and could select a containment or mitigation effort developed in collaboration with others, for example, installation agencies such as the Department of Public Works; the garrison/installation command; Medical Treatment Facility (MTF) departments; the MTF or installation emergency management office; higher-level commands or agencies; state or local health departments; or other Military Installation Departments of Public Health and on-post housing offices.</p> <p>Strategies could address, for example, aspects of the built environment (e.g., water quality, air or water pollutants, soil contamination such as brownfields, lead) or climate change; food deserts that affect the population served by the Military Installation Department of Public Health; low rates of certain vaccinations; contact tracing or sexually transmitted infection (STI) partner notification involving undocumented individuals; access to safe conditions in the home, workplace, and congregate living environments (including the barracks) during outbreaks; isolation or quarantine for individuals who are geographically or socially isolated; ensuring people have access to groceries or essential supplies during isolation or quarantine; or addressing transportation barriers to, for example, accessing food banks, accessing follow-up treatment, or receiving emergency biologics or prophylaxis, especially for one-car households or those with restrictions for on-post ride-sharing services or delivery services.</p>
<p><b>Measure 2.1.6 A Collaborate through established partnerships to investigate or mitigate public health problems and environmental public health hazards.</b></p>	<p><b>Required Documentation 1:</b>  The intent of this requirement is to work collaboratively on an investigation or mitigation, not to have another entity such as a regional military entity, Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), or civilian local or state health department carry out the investigation on the health department's behalf.</p> <p>The Military Installation Department of Public Health might consider coordinating investigation, mitigation, or containment of health problems, occupational health hazards, or other environmental hazards with civilian state or local health departments where military, local and/or state jurisdictions overlap or are adjacent. The examples could also reflect how the Military Installation Department of Public Health worked in partnership with other military agencies at the installation level, such as Child and Youth Services (CYS), other installation management assets (e.g., Installation Management Command assets, such as garrison/installation agencies), unit-specific preventive medicine or force health protection officers, military regional or other commands, Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), or other state or local government departments to demonstrate the capacity to conduct collaborative investigation or mitigation action. Documentation could include, for example, a completed After Action Report (AAR), Executive Summary (EXSUM), Memorandum for Record (MFR), Organizational Inspection Program (OIP) report, Staff Assistance Visit (SAV) report, or narratives of examples.</p> <p>If there has not been an event within the timeframe, one or more reports of drills or exercises may be provided to meet the number of examples required (i.e., two examples; narratives of examples are acceptable). The Military Installation Department of Public Health is not required to be the lead agency but must have participated in the drill(s) or exercise(s). For Military Installation Departments of Public Health that have not had an investigation within the timeframe, drills performed by Medical Treatment Facility (MTF), garrison/installation commands, other installation or mission/tactical entities, other military public health entities or military</p>

	<p>Commands or Agencies, as well as civilian agencies such as state or local health departments, can be used for documentation if the Military Installation Department of Public Health can describe how it participated in the drills.</p>
<p><b>Measure 2.1.7 A</b>  <b>Use surveillance data to guide improvements.</b></p>	<p><b>Required Documentation 1:</b>  For Military Installation Departments of Public Health, reports may be generated from infectious disease reporting systems, such as the United States Department of Defense’s Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), the Defense Occupational and Environmental Health Readiness System (DOEHRS), the Disease Reporting System internet (DRSi), the Defense Medical Surveillance Site (DMSS), or an applicable state health department surveillance system. The reports may be generated from the same or different systems for the two reportable or notifiable conditions.</p> <p>Military Installation Departments of Public Health may use reports or excerpts of reports generated by others, such as partner or higher-level agencies such as state health departments, Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), Armed Forces Health Surveillance Division (AFHSD), or a service-specific medical department, as long as the reports contain data that pertain to the jurisdiction or population served by the Military Installation Department of Public Health.</p> <p><b>Required Documentation 2:</b>  The Military Installation Department of Public Health could consider surveillance data generated from surveillance systems, as well as data used in reports available from partner agencies or higher-level agencies such as Acute Respiratory Disease Weekly Surveillance Summary, Weekly Influenza Activity Report, Department of Defense Suicide Event Report (DoDSER), <i>Health of the Force</i> report, or daily reports of patterns of disease incidence. Surveillance data could be used to identify difference in population groups, for example, considering age, gender, race/ethnicity, previous deployment status, service member military occupational specialty (MOS), military rank, or other factors to examine disparities between subpopulations, or other demographic variables.</p> <p><b>Required Documentation 3:</b>  Military Installation Departments of Public Health may have little or no influence to modify or improve surveillance systems or containment or mitigation strategies based on surveillance data; however, the example could address internal process improvements used by staff to ensure surveillance data are consistently received, or received in a timely manner, by examining gaps or lags in reporting among surveillance sites. The examples could also address improvements made to processes to use surveillance data generated to inform containment or mitigation strategies (e.g., identifying an increase in conditions and developing new/revised protocols to more effectively provide prophylaxis measures, such as vaccination based on geographic area or subpopulation). The examples could also demonstrate how staff improved the processes to use surveillance systems, such as expanding use of systems, or changes to more rapidly or accurately use surveillance system data, or enhancements to ensure surveillance system fields collect appropriate information (e.g., demographic data), based on an examination of existing surveillance data collected. The examples could also address enhancements to staff training to ensure all data fields are accurately entered, or methods to standardize data collection, analysis, or use. Since the surveillance systems for Military Installation Departments of Public Health are typically maintained by other agencies, and direct enhancements to the system are not usually within the department’s control, examples could also demonstrate how the Military Installation Department of Public Health provided feedback to one or more agencies that manage a specific surveillance system. This could include completing a feedback form or survey at the request of one of those agencies or sending an email to the surveillance system’s point of contact with a suggested improvement.</p>

**STANDARD 2.2**

## Prepare for and respond to emergencies.

### Foundational Capability Measure

**Measure 2.2.1 A**  
**Maintain a public health emergency operations plan (EOP).**

**Required Documentation 1.**  
**For required element b, indicate the portion of the EOP that addresses the roles and responsibilities of the Military Installation Department of Public Health and its partners, including, but not limited to, the PHEO or Assistant PHEO. This description in the plan will cover broad responsibilities of emergency response personnel (separate from those specific to the areas listed in required element e).**

The Military Installation Department of Public Health's Emergency Operations Plan (EOP) pertains to the military's "public," or population served. The guidelines may be defined by a military service department, Department of Defense (DoD), the state health department, or by a Federal or state agency, such as an office of emergency management. The plan may be a standalone document that delineates the health department's roles and responsibilities for public health emergencies, or it may be a section within a larger EOP, such as the installation's EOP, the Medical Treatment Facility's (MTF's) EOP, or another applicable plan.

#### Required element b:

The incident command system, as stated in *The Standards*, may not be applicable within the Military Installation Departments of Public Health as this may only involve those responsible for participating in the installation's Emergency Operations Center (EOC). If this is the case, these departments should consider and describe the designation of staff responsibilities or staff position(s) responsible for coordinating a response *within* the department in an emergency, as well as staff roles and responsibilities, including, but not limited to, the public health emergency officer (PHEO) or Assistant PHEO (APHEO), if those positions are filled by Military Installation Department of Public Health personnel.

#### Required element c:

In addition to populations outlined within *The Standards*, the Military Installation Department of Public Health might also consider, for example, junior enlisted (those aged 18–24 within lower enlisted ranks); single service members; those served by the Exceptional Family Member Program (EFMP); individuals who identify as LGBTQ+; communities of color; individuals who are visually impaired, deaf, or hard of hearing; one-car households; or individuals with other disabilities.

#### Required element e:

The Documentation Form contains a table in which the Military Installation Department of Public Health will indicate for each of the seven areas listed which agency(ies) or official(s) is designated as the lead, whether it is the Military Installation Department of Public Health, or partner agency, or other official (e.g., Medical Treatment Facility (MTF), Medical Emergency Manager (MEM), installation emergency management, logistics department, behavioral health chief, traumatic event management (TEM) team, installation's Directorate of Emergency Services (DES), Senior Commander). The Military Installation Department of Public Health will also use the Documentation Form table to indicate page numbers where the health department's responsibilities (if any) for each of those seven areas are described within the Emergency Operations Plan (EOP), annex(es), or attachment(s). If the MEM, installation emergency manager, Incident Commander, or Senior Commander, is the responsible official for carrying out the function or designating a lead agency based on the specific emergency, then that will be indicated in the Documentation Form for each area where it applies. In some areas, the Public Health Emergency Officer (PHEO) or Assistant PHEO (APHEO) may make a recommendation or be a consultant to the lead agency or official but is not responsible for carrying out the function or designating an agency or official to do so; that should also be indicated in the Documentation Form for each area where it applies, along with the actual lead agency or official.

#### Required element f:

The process to declare a public health emergency could include, for example, what authorities are needed, or the steps needed to make an official emergency declaration and specify the role of the health department in this process. This could include the steps (formal or informal) the Military Installation Department of Public Health would take, such as making a recommendation to the Senior Commander, as well as formal steps other entities take to declare a public health emergency. If the Public Health Emergency Officer (PHEO) and/or Assistant PHEO (APHEO) has a role in this process, but the PHEO or APHEO for the installation is not a staff member of the Military Installation Department of Public Health, then the roles for the PHEO and/or APHEO and the health

	<p>department, if any, should both be described. Process steps that are not formally documented in a plan, Standard Operating Procedure (SOP), regulation, etc., may be described in the Documentation Form.</p> <p><b>Required element h:</b> The process to revise the Emergency Operations Plan (EOP) might consider, for example, updates to guidance from the Centers for Disease Control and Prevention (CDC) or other national, state, or regional entities; specification from the Defense Health Agency (DHA), Department of the Army (DA), or other military service departments or DoD entities, including regulations or procedural instructions; or updates based on conducting a review meeting or examining results of Executive Summaries (EXSUMs) or After Action Reports (AARs), correspondence, or other processes.</p>
<p><b>Measure 2.2.3 A</b> <b>Maintain and expedite access to personnel and infrastructure for surge capacity.</b></p>	<p><b>Required Documentation 1:</b> For Military Installation Departments of Public Health, the availability of equipment to support a surge could include equipment available or that would be deployed beyond that of the department that may include, but is not limited to, equipment available on the installation, at the Medical Military Treatment Facility (MTF), a regional partner or other Military installation Department of Public Health, Department of Defense (DoD), Defense Health Agency (DHA) or other agency used for transportation, field communications, personal protective equipment (PPE), etc. The inventory or other documentation could be contained within the installation, hospital, and/or regional Emergency Operations Plan (EOP), or other standard operating procedure (SOP).</p> <p><b>Required Documentation 2:</b> <b>For required element a:</b> For Military Installation Departments of Public Health, the process(es) for expedited administrative procedures could describe how the department receives emergency funds that are made available directly from a military service department (e.g., the Army) or the Defense Health Agency (DHA), for example.</p> <p><b>For required elements b:</b> The process or set of process(es) for managing or hiring the workforce may be those of the Military Installation Department of Public Health or Medical Treatment Facility (MTF) and may be contained in the Emergency Operations Plan (EOP). This could include, for example, leveraging the MTF's nursing pool, obtaining personnel assigned on a detail from a higher headquarters or other military agency, or training additional health department staff on how to conduct contact tracing.</p> <p><b>For required element c:</b> The process or set of process(es) for contracting or procuring mutual aid (required element c) may be those of the Military Installation Department of Public Health or Medical Treatment Facility (MTF) and may be contained in the Emergency Operations Plan (EOP).</p>
<p><b>Measure 2.2.4 A</b> <b>Ensure training for personnel engaged in response.</b></p> <p><b>Required Documentation 1.</b> <b>The Military Installation Department of Public</b></p>	<p><b>Required Documentation 1:</b> The intent of this requirement for Military Installation Departments of Public Health is <b>not</b> to require training on incident command among all staff who may assist in a surge situation. Rather, the intent is to ensure department staff are provided with the training necessary to perform their emergency response roles and responsibilities (which may vary based on position, role, or rank/grade, etc.). Often, the Military Installation Department of Public Health may not have any personnel assigned to perform in an incident command structure (ICS), as functions may be performed outside of the Military Installation Department of Public Health (e.g., by the emergency manager, emergency management coordinator, or Public Health Emergency Officer (PHEO) or Assistant PHEO (APHEO)).</p>



<p><b>Health (DPH) must provide the schedule for training or exercises to prepare Military Installation Department of Public Health personnel who will serve in an emergency response capacity.</b></p> <p><b>Incident command or basic FEMA IS 100, 700 and 800 training is required <i>only</i> for those health department personnel, <i>if any</i>, who are performing ICS roles in the installation emergency operations center (EOC) and is not required of all DPH personnel. Other relevant training that is appropriate for those health department staff with emergency response role(s) outside of the installation EOC's ICS may be also provided and should be included in the schedule.</b></p>	<p>The Military Installation Department of Public Health will base its schedule for training or exercises on the role personnel would serve in an emergency situation. The schedule for training or exercises is based regulation, policy, or another authority, such as an Army Regulation (AR). At the time of this publication, the schedule for training or exercises is contained in AR 525–27 and Department of the Army Pamphlet (DA PAM) 525–27. The schedules for training or exercises are generally contained within the Public Health Emergency Operations Plan (EOP), a separate multi-year training and exercise plan, or standard operating procedures (SOPs)/protocols or regulations.</p> <p><b><u>Required Documentation 2:</u></b> Proactive or just-in-time training could include, for example, training on contact tracing, mass vaccination, cleaning and disinfection protocols, or use of specialized insect traps. The trainings used to demonstrate this requirement may be provided by another entity, such as the Medical Treatment Facility (MTF), garrison/installation, service-specific department, Defense Centers for Public Health (DCPH)/Defense Health Agency Public Health (DHA Public Health), Defense Health Agency (DHA), or their contractors.</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 2.2.5 A</b></p> <p><b>Maintain and implement a risk communication plan for communicating with the public during</b></p>	<p><b><u>Required Documentation 1:</u></b> The risk communication plan may address functions or processes performed by the public affairs office (PAO) at the Medical Treatment Facility (MTF) and/or the installation, or in conjunction with the PAO. Examples of documentation include a public affairs communications plan or risk or crisis communications plan or standard operating procedure (SOP)* and should involve the applicable PAO (e.g., installation, MTF, Defense Health Agency (DHA), and/or service-specific partners).</p> <p>*Note: Documentation for this requirement may be similar in intent or the same as that used for MTF health care accreditation. If applicable, coordinate with appropriate entities within the MTF to identify whether the health care accreditation documentation may also apply to and/or support this public health accreditation requirement. However, note that documentation assessed as acceptable</p>

<p><b>a public health crisis or emergency.</b></p>	<p>by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p><b>For required element a:</b> In addition to the guidance, Military Installation Department of Public Health resources used as part of the process to develop accurate and timely messages might also describe communications or fact checking with others, such as state or local health departments, the Defense Centers for Public Health (DCPH), Defense Health Agency (DHA), and/or in conjunction with the relevant public affairs office (PAO) (e.g., the PAO at the Medical treatment Facility (MTF), installation, etc.).</p> <p><b>For required element b:</b> In addition to the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could describe methods to communicate with the entire community by developing relationships with the media, organizations, or other outlets for reaching individuals with disabilities, those who do not speak English or for whom English is a second language, and other members of the public served by the Military Installation Department of Public Health who require particular communication considerations. Those methods may involve the applicable public affairs office (PAO) (e.g., installation, Medical Treatment Facility (MTF), etc.). This communication could be media on and/or off the installation (e.g., on-post newspaper or civilian media).</p> <p><b>For required element c:</b> The methods used to address misconceptions and misinformation need not be developed by the Military Installation Department of Public Health but could come from reputable sources or partners, including, but not limited to, the Defense Health Agency (DHA) Headquarters or other agency elements (e.g., Defense Health Agency Public Health (DHA Public Health)/Defense Centers for Public Health (DCPH)), Centers for Disease Control and Prevention (CDC), or state or local health departments.</p> <p><b>For required element g:</b> For Military Installation Departments of Public Health, the process to coordinate the communications and development of messages could include work with higher headquarters (e.g., up the military chain of command, or up through Defense Health Agency (DHA) channels), as well as with other regional partners, military service departments, mayors or boards of commissioners of neighboring communities, or local or state health departments.</p> <p><b>For required element h:</b> For Military Installation Departments of Public Health, the list with contact information may include media contacts or outlets on-post, off-post, or both.</p> <p><b>For required element i:</b> The procedure for keeping the media contact list current and accurate may describe the process used by the Public Affairs Office (PAO) at the Medical Treatment Facility (MTF) or installation.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 2.2.6 A</b> <b>Maintain and implement a process for urgent 24/7</b></p>	<p><b>Required Documentation 1:</b> The communication protocol, process, or system, other than the Health Alert Network (HAN), may be a state system or similar system in which the Military Installation Department of Public Health participates. The installation or Medical Treatment Facility (MTF) may establish a smaller system for providers and responders within the jurisdiction of the Military Installation Department of Public Health. The process, protocol, or system for sending 24/7 messages does not need to be the same process, protocol, or system for receiving 24/7 messages. For example, receipt of 24/7 messages may be via the state-wide HAN and/or a 24/7 call-line, while sending 24/7 alerts may be via a phone tree or email message.</p>

<p><b>communications with response partners.</b></p>	<p><b>For required element a:</b> The list of response partners (that minimally includes health care providers, emergency management, emergency responders, and environmental health agencies) may include on- and off-post partners within these categories and likely also would include the Medical Treatment Facility (MTF) Commander or Command Team, and emergency management at the MTF or installation.</p> <p><b>For required element b:</b> If separate processes, protocols, or systems are used for sending and receiving messages, the description or documentation should include how 24/7 alerts are both sent and received.</p> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, evidence that the protocol, process, or system for sending an alert to emergency response partners provided in Required Documentation 1 has been used or tested could include, for example, email messages, website reports or screenshots, an After Action Report (AAR), Information Paper, or other similar record of the test or actual alert.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 2.2.7 A</b> <b>Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.</b></p>	<p><b>Required Documentation 1:</b> For Military Installation Departments of Public Health, the plan for conducting response exercises (which includes how elements of the Emergency Operations Plan (EOP), or annexes, have been or will be tested) may pertain to the installation's, Medical Treatment Facility's (MTF's), or other applicable EOP. At the time of this publication, the schedule for Army exercises is contained in Army Regulation (AR) 525–27 and Department of the Army Pamphlet (DA PAM) 525–27. The schedule for exercises may also be contained within the public health EOP, a separate multi-year training and exercise plan, or standard operating procedures (SOPs)/protocols or regulations.</p> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, documentation might include, for example, an After Action Report (AAR) and/or Executive Summary (EXSUM) based on an actual or simulated emergency (drill or exercise) and containing required elements a–e.</p> <p><b>For required element c:</b> Response partners might include, for example, other health departments (state, Tribal, local, or other Military Installation Departments of Public Health) during the real event or drill/exercise. Emergency response partners may be on-post partners or commands such as the Medical Treatment Facility (MTF), emergency services, and safety; other military commands or agencies; or state or local civilian emergency services agencies, including law enforcement and hospitals.</p> <p><b>For required elements d and e:</b> Documentation must describe notable strengths (d) and a listing of and timetable for improvements(s) and could include debriefing or evaluation of strengths and improvements made based on reports from the event or drill/exercise. Examples could be an evaluation report, minutes from a debrief, hot-wash, or the After Action Report (AAR) produced by the Military Installation Department of Public Health, Medical Treatment Facility (MTF), installation Directorate of Plans, Training, Mobilization and Security (DPTMS), or a partner agency.</p>

## 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.**

#### Foundational Capability Measure

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

#### **Required Documentation 1:**

The department-wide procedures for ongoing, non-emergency communication outside the Military Installation Department of Public Health may be developed by or in conjunction with higher chains of command, the installation, or Medical Treatment Facility (MTF) public affairs office (PAO), or others, as long as they reflect the procedures used by the Military Installation Department of Public Health.

#### **For required element a:**

In addition to the examples provided in *The Standards*, the Military Installation Department of Public Health could consider processes to ensure information is accurate and complete, without communicating misinformation or omitting information, by fact checking with subject matter experts, such as those at the Defense Health Agency (DHA), the Department of Defense (DoD), or military service departments; or research and evaluation partners, such as the U.S. Army Research Institute for Behavioral and Social Sciences (ARI), the Army Research Office (ARO), Walter Reed Army Institute of Research (WRAIR); colleges or universities; or state or neighboring local health departments. Processes to ensure communications are timely might reflect message clearance processes up the chain of command, including, but not limited to, processes performed by the installation or MTF public affairs office (PAO) to expedite clearance or approval.

#### **For required element b:**

Methods to tailor communication might include, for example, designing messages or communications for audiences based on location or housing arrangements, for example, units, workplaces on post, on-post residents, those on post due to a recent Permanent Change of Station (PCS) or current Temporary Duty Travel (TDY), congregate living, those in 2-week training, or those living in tents (e.g., during field exercises). Messages could also be tailored to meet the needs of transient, temporary, or displaced individuals (e.g., refugees) staying on the installation. Methods could also describe the use of translators for those with limited English proficiency or use of sign language interpreters or technology to support the needs of those with hearing and/or visual impairments.

#### **For required element c:**

Community partners might include those on- or off-post including community or volunteer organizations (e.g., Family Readiness Groups (FRGs), spouses' clubs, or social or recreational facilities, such as Morale Welfare and Recreation (MWR) facilities. The process might also describe, for example, coordination with local or state health departments, coordination between two public affairs offices (e.g., installation, or Medical Treatment Facility (MTF)), or coordination with community partners to promote the dissemination of consistent and unified public health messages that are accurate and appropriate for the audience.

#### **For required element d:**

	<p>The process to maintain a contact list of key stakeholders for communications may be described within processes, protocols, standard operating procedures (SOPs), or other descriptions, which might include responsibilities of the public affairs office (PAO).</p> <p><b>For required element e:</b>  For Military Installation Departments of Public Health, the public information officer for regular communications may be designated as a Public Affairs Officer or Assistant Public Affairs Officer at a broader or umbrella agency, such as the Medical Treatment Facility (MTF) or installation, or another position serving as the Military Installation Department of Public Health's designated contact for regular communications outside of the department. The responsibilities may be performed by multiple individuals within the public affairs office(s) (PAO) (for example, community relations, media, or command information branches at the installation) or others with whom the department works. Responsibilities for maintaining media relationships; creating appropriate, effective public health messages; and managing other communications activities may be described, for example, within a job description, standard operating procedure (SOP), regulation, or other description of responsibilities.</p> <p>*Note: Documentation for this requirement may be similar in intent or the same as that used for MTF health care accreditation. If applicable, coordinate with appropriate entities within the MTF to identify whether the health care accreditation documentation may also apply to and/or support this public health accreditation requirement. Note, however, that documentation assessed as acceptable by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p><b>Required Documentation 2:</b>  Specific communication services may mean those provided to individuals who are non-English-speaking, have low literacy levels, or have hearing impairments. These services are provided as needed, based on demographic data. The services do not have to be provided directly by the Military Installation Department of Public Health but must be available when needed. For example, access to translation or TTY/TDD/TT communication services may be demonstrated through a current agreement maintained by the Medical Treatment Facility (MTF), and the Documentation Form could be used to describe how the Military Installation Department of Public Health relies on and accesses those services.</p> <p><b>Required Documentation 3:</b>  For Military Installation Departments of Health, evidence of working with the media to provide non-emergency communication could include work performed in conjunction with the public affairs office(s) (PAO) (community relations or command information branches, for example, at the installation/garrison) with whom it works. This communication could be media on and/or off the installation (e.g., on-post newspaper, civilian media). Examples of working with the media might include print media, radio, television, bloggers, web reporters, social media, and diverse media outlets (e.g., installation/garrison or installation bulletins or similar media publications; radio stations; community newspapers; ethnically targeted and non-English language newspapers or radio stations, etc.).</p>
<p><b>Measure 3.1.2 A</b>  <b>Establish and implement a department-wide brand strategy.</b></p>	<p><b>Required Documentation 1:</b>  Branding strategies that may be used are those specifically developed by or in use at the Medical Treatment Facility (MTF) or a higher headquarters agency or command, if permitted for use by and actively used by the Military Installation Department of Public Health. The branding strategy may be based upon branding already in use at a higher level but should be specific to the Military Installation Department of Public Health.</p> <p><b>Required Documentation 2:</b>  In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate implementation of the department-wide branding strategy (for required elements a–c) through materials that convey the presence of</p>

	<p>the health department and value of public health through the Military Installation Department of Public Health’s website or the website of a higher-level command or agency. For example, the Military Installation Department of Public Health could use screenshots of a web posting conveying the presence of the installation and value of public health as a page within the Medical Treatment Facility (MTF) or installation website. The Military Installation Department of Public Health could also demonstrate conveying information about the installation, public health’s value, and its brand and logo, inserted as a section or part of communication or information materials (e.g., presentation, report, brochure, or social media pages, etc.) maintained by the Armed Forces Wellness Center (AFWC/AWC), installation, or MTF.</p> <p><b><u>Required Documentation 3:</u></b> Examples of photos from inside the Installation Department of Public Health could be of the signage showing room or office numbers, or a sign on or behind the welcome desk displaying the brand or logo. Examples of photos from outside the Installation Department of Public Health could be of the facility’s external-facing door or the installation building sign showing use of the logo or brand strategy (defined by the Military Installation Department of Public Health within Required Documentation 1).</p>
<p><b>Measure 3.1.3 A</b> <b>Communicate what public health is, what the health department does, and why it matters.</b></p>	<p><b><u>Required Documentation 1:</u></b> The Military Installation Department of Public Health might demonstrate communications about what public health is, what the health department does, and why it matters through, for example, advertisements; newspaper inserts; social media; web postings on the department’s, installation’s, and/or Medical Treatment Facility’s (MTF’s), website; email or fax listserv; brochures; services directories; or program flyers. Communication with the governing entity is defined as that with the commander to whom the Installation Department of Public Health’s chief reports that has responsibility for the Military Installation Department of Public Health or advisory board, such as the Medical Treatment Facility (MTF) command team, for example. The example could also reflect communication to an advisory group (e.g., Commander’s Ready and Resilient Council (CR2C), the Public Health Activity, installation/garrison agencies or command, Medical Treatment Facility (MTF) partners or command, or others).</p>
<p><b>Measure 3.1.4 A</b> <b>Use a variety of methods to make information available to the public and assess communication strategies.</b></p> <p><b><u>Required Documentation 1.</u></b> <b>Elements f (links to permits and license applications) and i (name of the health department director) are <u>not</u> required for Military Installation Departments of Public Health.</b></p>	<p><b><u>Required Documentation 1:</u></b> <b>For required element e:</b> Public health-related laws or codes can include military service-specific regulations (e.g., Army Regulation (AR) 40–5, Department of the Army Pamphlet (DA PAM) 40–11)) and Department of Defense (DoD), Defense Health Agency (DHA), or other military-specific regulations, directives, instructions, and/or codes (e.g., Tri-Service Food Code).</p> <p><b>For required element f:</b> Links to permits and license applications are <b><u>not</u></b> required for Military Installation Departments of Public Health.</p> <p><b>For required element h:</b> Links could include, for example, state or local health departments, or other Military Installation Departments of Public Health in the region; the DHA Public Health/Defense Centers for Public Health (DCPH), Defense Health Agency (DHA) market/network, or DHA; or others.</p> <p><b>For required element i:</b> The name of the health department director is <b><u>not</u></b> required for Military Installation Departments of Public Health.</p> <p><b>For required element k:</b> Comments may be collected through an email address or Interactive Customer Evaluation (ICE), for example. If comments are provided through the Medical Treatment Facility (MTF) website, such as through a contact link or page, the Military Installation</p>

	<p>Department of Public Health may use the Documentation Form to describe how comments applicable to the health department are routed by the MTF to the Military Installation Department of Public Health.</p> <p><b>Required Documentation 2:</b> The Military Installation Department of Public Health might work in conjunction with the public affairs office to provide information to the general public through social media. The social media sites may be those of other organizations that are used by the Military Installation Department of Public Health to disseminate messaging, including, but not limited to, the social media sites of the Armed Force Wellness Center (AFWC/AWC), installation/garrison, or Medical Treatment Facility (MTF).</p> <p><b>Required Documentation 3:</b> The Military Installation Department of Public Health might work in conjunction with a public affairs office to assess one communication strategy and then describe it. The communication strategies assessment may be of websites or social media sites used by the Military Installation Department of Public Health. Examples include the Military Installation Department of Public Health's content posted to the Armed Forces Wellness Center (AFWC), installation/garrison, or Medical Treatment Facility (MTF) website(s) or social media site(s); or other communication strategies (e.g., uptake of press releases/public service announcements (PSAs) among media outlets, etc.). Assessment of a communication strategy could also involve partnership with others who are assisting the Military Installation Department of Public Health with assessing communication strategies, including, but not limited to, a DHA market/network, or a partner agency such as the Defense Health Agency Public Health (DHA Public Health)/a Defense Center for Public Health (DCPH).</p>
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**STANDARD 3.2**  
**Use health communication strategies to support prevention, health, and well-being.**

<p><b>Measure 3.2.1 A</b> <b>Design communication strategies to encourage actions to promote health.</b></p>	<p><b>Required Documentation 1:</b> This requirement focuses on the approach used at the installation level related to communication strategies the Military Installation Department of Public Health will implement on its own, as well as the approach the Military Installation Department of Public Health uses to implement health-related communication strategies directed from a higher level or chain of command.</p> <p>The department-wide approach for developing and implementing communication strategies may be developed in conjunction with higher chains of command or agencies (e.g., Defense Health Agency (DHA), a military service department or command (e.g., U.S. Army Forces Command), a public affairs office (PAO), Medical Treatment Facility (MTF), or other partners (e.g., Commander's Ready and Resilient Council (CR2C) members), as long as it pertains to the approach used by the Military Installation Department of Public Health.</p> <p>When communication strategies are communicated to the Military Installation Department of Public Health (e.g., through a directive to push out a tobacco prevention campaign from the DHA, military service medical department, or military service department) that gives the Military Installation Department of Public Health discretion to modify or tailor communication strategies, the general approach used by the health department to tailor those communications will be included.</p> <p><b>For required element a:</b> While some communications may be pre-determined at a higher level or chain of command such as Defense Health Agency (DHA), where there is discretion on priorities, the Military Installation Department of Public Health's approach might consider methods to</p>
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	<p>determine that an issue is a priority, for example, based on data from the updated <i>Health of the Force</i> Online or other local data to identify priority populations or pressing needs for programming or services, as well as alignment with local or community-based priorities, Department of Defense (DoD), Defense Health Agency (DHA), or military service-specific priority(ies) or directive(s), etc.</p> <p><b>For required element b:</b> The intent is to describe the approach used to ensure communication strategies are rooted in evidence or science or have been tested. This determination could be based on, for example, internal planning meetings to validate the evidence base. Examples of sources of evidence-based or promising practices for health communication strategies may include the Centers for Disease Control and Prevention’s (CDC’s) Clear Communication Index, The Guide to Community Preventive Services, peer-reviewed literature, Defense Health Agency (DHA), Defense Health Agency Public Health (DHA Public Health)/a Defense Center for Public Health (DCPH), other military or civilian research institutions, or expert opinion when evidence is not available, etc.</p> <p><b>For required element c:</b> Priority populations could include, for example, active-duty service members; single service members, especially those living in the barracks; pregnant women; junior enlisted service members; and/or LGBTQ+ individuals. Examples of documentation include findings from a focus group, key informant interviews, or pull-aside testing. Documentation could also include minutes from a town hall meeting, planning meeting, community coalitions or collaboratives (e.g., Commander’s Ready and Resilient Council (CR2C) or CR2C Working Group meetings) with the priority population(s), or a meeting of an advisory group representing the priority population.</p> <p><b>For required element d:</b> For Military Installation Departments of Public Health, ensuring consistency within procedures for communications may be developed in conjunction with higher level agencies or chains of command, a public affairs office (PAO), Medical Treatment Facility (MTF), or others, as long as the methods to ensure consistency pertain to the communications procedures used by the Military Installation Department of Public Health and specified in Measure 3.1.1, Required Documentation 1.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 3.2.2 A</b> <b>Implement health communication strategies to encourage actions to promote health.</b></p>	<p><b>Required Documentation 1</b> In addition to guidance in <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate focusing on the prevention of a chronic disease as one of the examples within the Documentation Form if not directly evident within the documentation. Otherwise, the examples could demonstrate evidence of a chronic disease-focused strategy by the following, for example:</p> <ul style="list-style-type: none"> <li>• If the communication strategy is focused on tobacco use prevention, then the strategy itself will specify why to not use tobacco (e.g., preventing cancer or other health problems),</li> <li>• If the communication strategy is focused on promoting the use of pre-exposure prophylaxis (PrEP), then it should be stated that this is for the purpose of preventing HIV transmission, or</li> <li>• If the communication strategy is focused on increasing physical activity or increasing healthy eating, then it should specifically reference that this is for the purpose of heart disease, diabetes, or cancer prevention.</li> </ul> <p>The Documentation Form may also be used to indicate the source of an evidence-based practice or promising practice. In the military context, sources of evidenced-based or promising practices might include, for example, subject matter experts at the Defense Health Agency (DHA)/DHA Public Health (DHA Public Health)/a Defense Center for Public Health (DCPH), Department of Defense (DoD), or military service departments; or research and evaluation partners, such as the U.S. Army Research Institute for</p>



Behavioral and Social Sciences (ARI), the Army Research Office (ARO), Walter Reed Army Institute of Research (WRAIR), colleges, or universities.

Input gathered from the priority audience to shape the content or dissemination (required for one of the examples) might involve focus groups, key informant interviews, or pull-aside testing or townhall discussion held with stakeholders or community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs) or CR2C Working Group members), or an advisory group meeting. Input could also be collected from among civic groups or social organizations who are specifically tasked with representing those with lived experience or representing specific issues or subpopulations, such as junior enlisted (those aged 18–24 within lower enlisted ranks), Better Opportunities for Single Soldiers (BOSS), those served by the Exceptional Family Member Program (EFMP), individuals who identify as LGBTQ+, communities of color, individuals with special needs, such as those who are visually and/or hearing impaired, or individuals with disabilities.

**For required element a:**

The final content that references an action that members of the public should take could address, for example, ceasing tobacco use, increasing the intake of fruits and vegetables, obtaining preventive health services such as cancer screening, decreasing alcohol consumption, intervening in high-risk situations where they are a bystander, the importance of using condoms, seeking prenatal care early, or why to receive STI testing.

**For required element b:**

Additional examples of demonstrating that the Military Installation Department of Public Health strived for cultural humility and linguistic appropriateness include the application of learnings from Diversity, Equity, Inclusion, and Accessibility (DEIA) or related trainings. Linguistic appropriateness could be demonstrated by using military-specific terminology and graphics, especially for communications aimed at service members. If not evident in the examples, a description of the Military Installation Department of Public Health's approach may be provided in the Documentation Form.

**For required element c:**

In addition to the examples provided within *The Standards*, the Military Installation Department of Public Health may work in conjunction with the public affairs office (PAO) to share or distribute information to the public through websites or social media, which could include sites maintained by the Armed Forces Wellness Center (AFWC), installation/garrison, or Medical Treatment Facility (MTF) that are used by the Military Installation Department of Public Health.

**Required Documentation 2:**

To promote unified messaging, the Military Installation Department of Public Health could provide an example of coordinating with other installations (or those of other military services); health departments (Tribal, state, or local); community partners; the Military Treatment Facility (MTF) Commander; Defense Health Agency (DHA) headquarters, Defense Centers for Public Health/DHA Public Health; regional partners, such as a Medical Readiness Command or DHA market/network; the Senior Commander; or others. Documentation to demonstrate coordinated messaging with others who are providing public health information to improve public trust and reduce confusion could include, for example, an email or memorandum, minutes of meetings during which messaging was discussed, or a documented phone conversation during which the message was discussed.

## 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 promoting health through collaborative processes.

**Measure 4.1.1 A**  
**Engage in active and ongoing strategic partnerships.**

**Required Documentation 1:**

For Military Installation Departments of Public Health, the example of a collaborative activity that builds on an ongoing partnership with another organization could be conducted among entities from sectors other than public health, including entities on post, off post, or a mix of on- and off-post partners, as part of required elements a–d. Coalitions (e.g., Commander’s Ready and Resilient Council (CR2C) or CR2C Working Groups) in which the Military Installation Department of Public Health participates would **not** meet the intent and are covered in the following measure.

**For required element a:**

In addition to the examples provided within *The Standards*, the Military Installation Department of Public Health could consider an example of a collaborative activity that builds on an ongoing partnership with installation working groups or committees that involve Department/Directorate of Public Works (DPW) Housing, Emergency Services, Army Community Service (ACS) or other installation/garrison services or programs that address social determinants of health, such as financial readiness (Financial Readiness Program), Better Opportunities for Single Soldiers (BOSS), or Morale, Welfare, and Recreation (MWR). Partners could also include community organizations; social service providers/helping agencies, such as a food bank; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); local government, such as county or city health departments; not-for profit organizations; local businesses; military and community health care providers; or others.

**For required element d:**

The Military Installation Department of Public Health could demonstrate how an ongoing relationship led to a collaborative activity in a variety of ways. For example, the health department might demonstrate developing a referral system between providers external to the military health system as a result of an ongoing relationship with health care providers. The installation could also provide an example of leveraging an ongoing relationship with transportation agencies/offices as part of a collaborative strategy to link the home-bound or single-car households with needed care or services. Other examples might focus on how the installation department of public health’s ongoing relationship with behavioral health providers or tactical/mission units led to the implementation of a campaign to raise awareness or reduce stigma associated with seeking behavioral health services. The Military Installation Department of Public Health could also provide an example of how an ongoing relationship with a social service organization (e.g., Family Readiness Group (FRG)) or childcare providers (e.g., Child and Youth Services (CYS)) led to an arrangement for childcare for patients to enhance childcare utilization, etc.

**Foundational Capability Measure**

**Measure 4.1.2 A**  
**Participate actively in community health coalition(s).**

**Required Documentation 1:**

For Military Installation Departments of Public Health, current, active coalitions (not coalitions that have completed their tasks and disbanded) of which the health department is an active member may have been convened by the Military Installation Department of Public Health, the installation’s senior commander, the installation/garrison commander, another organization, agencies in neighboring civilian communities, or community members, etc. The Military Installation Department of Public Health might consider cross-sector coalition(s) already established or newly established. The coalition may address a wide range of community health issues and may be the same group that developed the community health assessment (CHA) or community health improvement plan (CHIP); or another group, such as a Commander’s Ready and Resilient Council (CR2C) or CR2C Working Groups (WGs). The health department may also consider local coalitions, which are often off-post, that address a single health topic of population, for example, a local tobacco prevention coalition, women’s health coalition, or substance abuse prevention coalition.

**For required element a:**

For Military Installation Departments of Public Health, the purpose or intended goals of the coalition may be outlined in, for example, a charter for an on-post coalition, website, or other promotional material (e.g., briefing slides or brochure). While the stated purpose or intended goals must address health disparities or inequities, for example, helping underserved or higher risk families, service members, or personnel, to meet the intent of this requirement, the specific terms “disparities” or “inequities” do **not** need to be included. PHAB is not prescriptive about the use of specific terminology which varies by jurisdiction; rather, PHAB focuses its review on meeting the intent of requirements. If it is unclear from the example how the coalition is addressing disparities or inequities, the Documentation Form may be used to explain that relationship.

**For required element b:**

Partners in the coalition could include, for example, on-post partners, such as Morale, Welfare, and Recreation (MWR); helping and resilience agencies or personnel (e.g., Army Community Service, Family Advocacy Program, Military Family Life Counselors, integrated prevention workforce); mission/tactical units; or installation services, such as the Directorate of Public Works/Housing (DPW), Directorate of Emergency Services (DES), or others. Partners in the coalition could also or alternatively include off-post partners or a mix of on- and off-post partners, which could include off-post community organizations (Rotary Club); social service providers/helping agencies (e.g., American Red Cross; Women, Infants, and Children (WIC)); local government, such as county or city health departments; not-for profit organizations; local businesses; health care providers; or others. Documentation might include, for example, a coalition membership list, meeting sign-in sheets, or other attendance rosters. If meetings are held in a virtual format (e.g., via MS Teams), a participant list may be provided. If the sector is unclear from the participant list, it may be indicated in the Documentation Form.

**For required element c:**

Community members could include, for example, individuals that represent populations who have lived experiences with, or are disproportionately affected by, conditions that contribute to poorer health outcomes, for example, individuals who represent high-risk, junior enlisted (those aged 18–24 within lower enlisted ranks); Better Opportunities for Single Soldiers (BOSS); those served by the Exceptional Family Member Program (EFMP); individuals who identify as LGBTQ+; communities of color; individuals with visual or hearing impairments; families with a service member that is deployed; or individuals with disabilities. In many cases, to meet this requirement, coalition membership will need to go beyond just unit or organizational representatives. If it is unclear from the documentation who the community members are, they may be indicated in the Documentation Form.

**Required Documentation 2:**

The strategies implemented through the work of the coalition(s) could be those tied to implementation of the Community Health Improvement Plan (CHIP), if that is carried out by one of the coalition(s) from Required Documentation 1. Both examples could be provided from the same coalition or different coalitions based on Required Documentation 1. The Military Installation Department of Public Health *might consider strategies implemented that reflect a change in the community, a change in policy, or a new or revised program or initiative through the **community coalition(s) or collaborative(s)*** such as offering healthier meal options in dining facilities or schools, improving access to social services (e.g., Family Advocacy Program (FAP); Women, Infants, and Children (WIC)); a financial readiness program; a sponsorship program, such as co-location of social services in a convenient location, or implementation of a coordinated referral system; incorporating behavioral or social service questions into screenings; referrals to off-post social services, etc. Strategies could also be implemented to address, for example, food deserts (i.e., areas that lack access to healthy foods); low rates of certain vaccines; or transportation barriers, for example, to access foodbanks, access follow-up treatment, or receive emergency biologics or prophylaxis, especially for one-car households or those with restrictions for ridesharing on-post or delivery services on post, that affect the population served by the Military Installation Department of Public Health.

<p><b>Measure 4.1.3 A</b>  <b>Engage with community members to address public health issues and promote health.</b></p>	<p><b>Required Documentation 1:</b>  For Military Installation Departments of Public Health, efforts to promote active participation or eliminate barriers could consider the installation community as a whole, or a specific group that will be most affected by a policy or strategy. The intent of this requirement is to engage individual community members, not an organization representing population groups. Strategies may be led by the health department, or it might participate in these strategies with others, such as coalitions or collaboratives of which it is a part (e.g., Commander’s Ready and Resilient Council (CR2C) or CR2C Working Groups (WGs), an off-post coalition, Army Family Action Plan (AFAP), etc.). The Military Installation Department of Public Health might consider a strategy implemented to encourage active participation or eliminate barriers among members of the population served by the Military Installation Department of Public Health or a particular group of people within that population (e.g., adolescents, single service members, service members who are single parents, Department of Defense (DoD) Civilians, or retirees). Encouraging active participation could include strategies that promote open dialogue or create spaces where participants feel comfortable speaking candidly, including, but not limited to, listening or sensing sessions, focus groups, town hall meetings, or other methods of dialogue. Eliminating barriers could include strategies that reduce stigma around sensitive public health topics; providing childcare or transportation; or other incentives (e.g., a 59-minute early release to civilian and military personnel).</p>
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**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.**

<p><b>Measure 5.1.1 A</b>  <b>Maintain awareness of public health issues that are being discussed by those who set policies and practices that impact on public health.</b></p>	<p><b>Required Documentation 1:</b>  In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health could also demonstrate that it is informed of public health issues discussed by the Medical Treatment Facility (MTF) commander and/or other commands or entities that set policies and practices that impact the health department or the health of the population it serves. For example, the Military Installation Department of Public Health might monitor public health-related instructions, policies, regulations, execution orders, operations order, or equivalent of the Department of Defense (DoD), the Defense Health Agency (DHA), military service department, or the military medical service department or installation/garrison or installation senior commander. These could include monitoring decisions by the installation or MTF commanders or command teams, those of neighboring local communities, or state level, or higher levels of the Federal government that the Military Installation Department of Public Health has no legal authority to enforce but that has implications for the health of the public served by the Military Installation Department of Public Health. Examples of such policies and practices include a tobacco-free medical campus policy, policy directing on-post alcohol sales hours, motorcycle safety, and hands-free device driving policies on post.</p> <p>Examples of documentation include meeting minutes and agendas showing participation in community coalitions or collaboratives (e.g., Commander’s Ready and Resilient Councils (CR2Cs) or CR2C Working Groups, military, DHA, or local civilian community public health synchronization or information meetings) showing discussion of policies or laws and their impact on health; Executive Summaries (EXSUMs), Information Papers (IPs), or situation reports showing the Military Installation Department of Public Health remains aware of public health policy issues, or reviews and tracks issues discussed by relevant commands or other policy proponents for the community served by the Military Installation Department of Public Health. Military Installation Department of Public Health membership on a DoD-related, local, state, or national listserv that discusses public health policy issues or shares updates on, or reports of, policy-related activities may also be used as documentation.</p>
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<p><b>Foundational Capability Measure</b></p>	<p><b>Required Documentation 1:</b></p>
<p><b>Measure 5.1.2 A</b> <b>Examine and contribute to improving policies and laws.</b></p>	<p>Reviews may be of a regulation that the Military Installation Department of Public Health monitors, or a military service-specific regulation, Department of Defense (DoD) instruction (DoDI), Defense Health Agency (DHA) procedural instruction or equivalent, an operations order or equivalent, policy (military or local) including those at a higher level that the Military Installation Department of Public Health has no legal authority to monitor or enforce but that has implications for the health of the public served by the Military Installation Department of Public Health. The documentation may address the review of protocols and/or adherence to protocols and not a review of a regulation itself. This is a program review and does <b>not</b> require a legal review.</p> <p>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 Military Installation Department of Public Health could, for example, provide a briefing, an Executive Summary (EXSUM), a completed comment review matrix (CRM), a White Paper, Information Paper (IP), or some other record of the discussion of the review and findings. Those who set or influence policy could include governing entities such as the Medical Treatment Facility (MTF) commander or advisory board, for example, the MTF command team; the installation commander or command team; boards of health of neighboring local health departments; local, state, or federal legislative bodies or elected officials; DoD, DHA or the military service departments; local boards of education or transportation; or the installation's senior commander.</p> <p><b>For required element a:</b> Examples of evidence-based practice can be from various sources, including The Guide to Community Preventive Services; peer-reviewed journals; subject matter experts at Defense Centers for Public Health (DCPHs), Defense Health Agency (DHA), Department of Defense (DoD), or military service departments; or research and evaluation partners such as the U.S. Army Research Institute for Behavioral and Social Sciences (ARI), Army Research Office (ARO), Walter Reed Army Institute of Research (WRAIR); colleges; or universities.</p> <p>Due to the limited availability of evidenced-based practices or promising practices for military communities, Military Installation Departments of Public Health could provide examples of practice-based evidence, including, for example, drawing from the lessons learned or best/promising practices identified from similar policies or practices implemented at other military installations.</p> <p><b>For required element c:</b> Input might be gathered from stakeholder or strategic partners, for example, other commands, other military installation departments of public health or neighboring local health departments, or installation proponents and agencies and departments such as the Army Substance Abuse Program (ASAP); behavioral health; Child and Youth Services (CYS); Directorate of Plans, Training, Mobilization and Security (DPTMS); on- or off-post community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs) or CR2C Working Group members); or an advisory group (e.g., Medical Treatment Facility (MTF) command team) meeting.</p>

**STANDARD 5.2**

**Develop and implement community health improvement strategies collaboratively.**

For Military Installation Departments of Public Health, the CHIP and related processes must address the jurisdiction served which, at a minimum, includes all beneficiaries enrolled to the installation Medical Treatment Facility (MTF) (e.g., active-duty military personnel, their families; and retirees, when applicable), the DoD Civilian workforce assigned to the installation (for occupational health purposes only), and military units assigned to the installation.

**Measure 5.2.1 A**  
**Engage partners and members of the community in a community health improvement process.**

**Required Documentation 1:**

The current adopted model for community health improvement planning process for Military Installation Departments of Public Health at Army locations is Mobilizing for Action through Planning and Partnerships (MAPP). The Military Installation Department of Public Health could refer to a model to describe the collaborative process used in required elements a–d, such as MAPP or another model, if used.

**For required element a:**

In addition to the examples of participating partners provided within *The Standards*, the Military Installation Department of Public Health could consider engaging a wide variety of partners in the community health improvement planning process. Organizations representing sectors other than public health on post include, for example, mission/tactical mission assets such as brigades, battalions, companies, public affairs office (PAO), headquarters; medical assets, such as nursing, behavioral health, or clinical operations; community organizations and personnel, such as family readiness groups, spouses' clubs, integrated prevention workforce, and Morale, Welfare, and Recreation (MWR); social service providers/helping agencies such as the Family Advocacy Program (FAP); installation/garrison services such as the Directorate of Public Works Housing (DPW), Directorate of Emergency Services (DES), Army Community Service (ACS) or other installation/garrison services or programs that address social determinants of health, such as financial readiness (Financial Readiness Program), Child and Youth Services (CYS); and safety. Organizations representing sectors other than public health off post include, for example, local government of neighboring communities; and local businesses, education, transportation, or law enforcement. The partnership for community health improvement process may be connected to or may be the same partnerships or coalitions referenced in the standards and measures in domain 4 or may differ. The community health improvement planning partnership can be comprised of just on-post partners, or a mix of on- and off-post partners.

The partnership must include community members from the population served by the Military Installation Department of Public Health directly or include organizations representing those populations who are disproportionately affected by conditions that contribute to poorer health outcomes or for whom systems of care are not appropriately designed. For Military Installation Departments of Public Health, individuals or organizations representing populations who have lived experiences with, or are disproportionately affected by, conditions that contribute to poorer health outcomes could include, for example, junior enlisted (those aged 18–24 within lower enlisted ranks) service members, Better Opportunities for Single Soldiers (BOSS), those served by the Exceptional Family Member Program (EFMP), individuals who identify as LGBTQ+, communities of color, individuals with special needs such as those with visual and/or hearing impairments, or individuals with disabilities. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form—for example, to clarify who the community member representatives are). Organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes could include, for example, community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs) or CR2C Facilitator), installation/garrison assets such as Morale, Welfare, and Recreation (MWR); or Family Advocacy Program (FAP), etc.

**For required element c:**

In addition to the examples provided within *The Standards*, the review of the causes of disproportionate health risks or health outcomes of specific populations might consider, for example, how system(s) may not be well designed to serve populations based on demographics, or social or structural determinants. For example, systems of care may not be well suited to equally meet the needs of individuals by age (e.g., teenagers, elderly, etc.), ethnicity, geographic location, transportation (e.g., one-car households), sexual orientation (e.g., LGBTQ+ populations), military affiliation, educational level attained, or mental or physical disabilities. Other factors might include, for example, discrimination (e.g., marriage inequality), other service needs (e.g., navigating parenthood while

	<p>on active duty, or balancing caring for families while meeting military regulations or responsibilities), service members experiencing pregnancy or postpartum, individuals with diabetes, etc. Other examples might also include causes related to populations who do not trust health care providers, stigma as a factor related to accessing care, or a lack of understanding by populations about why certain routine medical services or screenings are necessary to protect their health. The review of causes of disproportionate health risks or health outcomes may lead to strategies to address specific population needs regarding long wait times, lack of childcare during health care visits, lack of transportation to health care, fear of accessing particular services due to potential negative impacts on the service member's military career, cultural barriers, financial barriers to accessing vision or dental care for beneficiaries, or other factors.</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 5.2.2 A</b>  <b>Adopt a community health improvement plan.</b></p>	<p><b>Required Documentation 1:</b>  <b>For required element c:</b></p> <ul style="list-style-type: none"> <li>i. The intent is for each activity or strategy in the community health improvement plan to include both a timeframe and an organization or individual who has accepted responsibility for implementing it.</li> <li>ii. For Military Installation Departments of Public Health, policy recommendations may be related to housing, transportation, or utilization of available services, for example. Policies could also be locally based, for example, Child and Youth Services (CYS) policies or facility policies regarding healthy meal or vending options.</li> </ul> <p><b>For required element d:</b>  Community assets and resources could be any resource at the installation or in the broader community that could be used to improve the health of the community. Community assets and resources could include skills and attributes of military personnel and their families, participation of retirees, local on- and off-post organizations, educational opportunities, Morale, Welfare, and Recreation (MWR), institutions (e.g., faith-based organizations such as the chapel; local foundations; institutions of higher learning such as community colleges, universities, etc.), as well as other community factors such as parks, social capital and community cohesion, community resilience, community readiness, a supportive community, etc.</p> <p><b>For required element e:</b>  For Military Installation Departments of Public Health, the process used to track the status of the effort or results of actions taken to implement Community Health Improvement Plan (CHIP) strategies might involve use of an Information Paper (IP), spreadsheet, dashboard, database, workplan, or combination thereof.</p>
<p><b>Measure 5.2.3 A</b>  <b>Implement, monitor, and revise as needed, the strategies in the community health improvement plan in collaboration with partners.</b></p>	<p><b>Required Documentation 2:</b>  In addition to the guidance included in <i>The Standards</i>, documentation examples for Military Installation Departments of Public Health could include, for example, an interim progress report or briefing shared with the Community Health Improvement Plan (CHIP) partnership or an Information Paper (IP) to accompany a tracking document.</p> <p><b>Required Documentation 3:</b>  Documentation for this requirement should be an updated, revised Community Health Improvement Plan (CHIP). Revisions to the CHIP may be indicated for a specific section or multiple sections, for example, revised activities, timeframes, targets or assigned responsibilities based on implementation progress, an emerging health issue, changes in responsibilities, resources, or assets, etc. Revisions could be indicated, for example, through a revision table or summary of changes, or highlighting within the plan to indicate updates made. Although a full revision or updated version of the plan is not required, it could also be provided. If the plan was adopted less than a year before it was submitted to PHAB, the Military Installation Department of Public Health could provide revisions to an earlier plan, either as specific sections or full plan revisions. The Military Installation Department of Public Health could also provide detailed plans for a revision process if the plan has not been revised during the 2-year timeframe.</p>

<p><b>Foundational Capability Measure</b></p>	<p><b>Required Documentation 1:</b>          The Military Installation Department of Public Health’s internal policies and procedures of how health equity is incorporated as a goal into the development of programs (e.g., program plans or concept plans) that serve the community might consider specific populations such as, for example, those for whom English is a second language, junior enlisted service members, those who use Women, Infant, and Children (WIC) services, people with disabilities, those enrolled in the Exceptional Family Member Program (EFMP), those that are LGBTQ+, and racial/ethnic minorities. The Military Installation Department of Public Health could provide a policy or procedure it developed or that was developed by an umbrella agency (or another division of the umbrella organization), for example, the Medical Treatment Facility (MTF) or Defense Health Agency (DHA) market/network, as long as the policy or procedure also applies to the Military Installation Department of Public Health.</p>
<p><b>Measure 5.2.4 A</b>  <b>Address factors that contribute to specific populations’ higher health risks and poorer health outcomes.</b></p>	<p><b>Required Documentation 2</b>          For Military Installation Departments of Public Health, the example implemented strategy might address factors contributing to higher health risks and poorer health outcomes, or inequities of populations such as, for example, junior enlisted (those aged 18–24 within lower enlisted ranks) service members, single service members (e.g., those participating in Better Opportunities for Single Soldiers (BOSS), those served by the Exceptional Family Member Program (EFMP), individuals who identify as LGBTQ+, communities of color, individuals with special needs, such as those who are visually and/or hearing impaired or individuals with disabilities, etc.).</p> <p>In addition to those public health strategies listed in <i>The Standards</i>, potential public health strategies implemented may address social norms (e.g., those related to alcohol or tobacco use in the military), locally derived or adapted programs or initiatives, or policy changes that expand the availability of spousal employment options, or enhance unit cohesion.</p> <p>The strategy implemented could demonstrate efforts performed with stakeholders or partners such as organizations that represent populations or have expertise addressing inequities. Examples of such stakeholders or partners could include unit leaders; commanders; and civic groups who are specifically tasked with representing those with lived experience or representing specific issues or subpopulations.</p>

## Domain 6

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

Domain 6 focuses on the role of Military Installation Departments of Public Health in fostering compliance with public health-related regulations, executive orders, statutes, and other types of public health laws.

The terms “regulations” and “laws,” as used in *The Standards*, refers to ALL types of regulations, orders, policies, rules, statutes, ordinances, laws, case law, and codes that are applicable to the jurisdiction of the Military Installation Department of Public Health. Not all state statutes or local (e.g., county, city) ordinances apply to Military Installation Departments of Public Health and therefore may not need to be addressed.

Military Installation Departments of Public Health do not directly enforce public health-related regulations or rules. However, they have an important role in supporting compliance with such regulations and laws.

Public health regulations and laws are key tools for Military Installation Departments of Public Health as they work to promote and protect the health of the population that they serve. Military Installation Department of Public Health responsibilities related to public health regulations include educating about new or



revising existing regulations, policies, orders (including operation orders), or laws. Public health-related regulations should be science-based and protect the rights of the individual, as they also protect and promote the health of the population. Public health-related regulations or orders may not always originate from the Military Installation Department of Public Health, but the health department can educate the entities/individuals who issue regulations or direct orders about the public health impacts and considerations of the proposed regulation, order, or other policy. Military Installation Departments of Public Health have a role in educating regulated entities about the meaning, purpose, compliance requirements, and benefit of public health regulations, policies, and laws. Military Installation Departments of Public Health also have a role in educating the public about regulations, policies, and laws and the importance of complying with them.

## STANDARD 6.1

### Promote compliance with public health laws.

**Measure 6.1.1 A**  
**Maintain knowledge of laws to promote and protect the public's health.**

**Required Documentation 1:**  
**For Military Installation Departments of Public Health, the examples must demonstrate staff are provided with training on how enforcement authorities are carried out by other agencies with enforcement authority to promote and protect health.**

**Required Documentation 1:**

Military Installation Departments of Public Health do not have enforcement **authority** for any laws or regulations; however, they do participate in activities related to promoting compliance, such as conducting inspections and investigations. Even though Military Installation Departments of Public Health do not have enforcement **authority**, they still have a responsibility to maintain a working knowledge of laws and regulations that have the potential to impact public health for the community they serve. Examples must demonstrate how department staff receive training on relevant laws and regulations, including how enforcement activities are carried out by other agencies with enforcement authority (e.g., installation/garrison command, medical treatment facility (MTF) command, etc.). Examples must be from two different enforcement areas and dated within 2 years. Examples may include, but are not limited to, training received on the Tri-Service Food Code or the Army Child Development Services regulation.

**Measure 6.1.2 A**  
**Investigate complaints pertaining to public health regulations.**

**Required Documentation 1:**

The intent of this requirement is to describe how the Military Installation Department of Public Health responds to and investigates complaints received by the public (population served), partners, or other organizations or agencies within their area of responsibility. Written protocol(s) must include steps for follow-up, which might include logging complaints received, conducting initial investigations, generating reports of findings, and communications to regulated entities of what is needed to achieve compliance if warranted. If the Military Installation Department of Public Health is not mandated to conduct a particular complaint investigation, such as that related to issues in privatized housing or water issues under the authority of the installation Department of Public Works (DPW), the protocol(s) may address how the health department refers concerns or complaints to the appropriate agency with authority to conduct complaint investigations. The protocol(s) may address formal complaints, such as concerns raised by the public and/or informal concerns raised among staff. If **no** updates are made, the health department will describe the review process and explain why no changes were warranted.

	<p><b>Required Documentation 2:</b>          If the Military Installation Department of Public Health is not mandated to conduct complaint investigations, examples could demonstrate how the health department communicated concerns or complaints to the agency(ies) with authority based on protocol(s) in Required Documentation 1. For example, the health department could demonstrate implementation of its protocols to refer complaints received by providing an example of referring a complaint received about nuisances to the appropriate housing authority/agency.</p> <p>If the Military Installation Department of Public Health has authority to conduct complaint investigations for one or more programs, the example(s) will address conducting investigations based on concerns or complaints received based on protocol(s) in Required Documentation 1. For example, the health department could provide an example of implementing protocols by investigating a complaint received about a food service establishment, shop, or other worksite, through inspection report(s) outlining each step taken according to procedures (e.g., initial investigation findings, follow-up, and resolution and/or correspondence with the complainant and/or regulated entity).</p> <p>Other examples could demonstrate collaborating with appropriate agencies in response to concerns or complaints received. For example, following protocols to follow up by conducting complaint investigations, in collaboration with appropriate agency(ies), of reported noxious odors, potential water contamination, or other issues. The examples may also demonstrate how the Military Installation Department of Public Health collaborated with other agencies, including those with authority during investigations, according to the installation's protocols.</p>
<p><b>Measure 6.1.3 A</b>  <b>Conduct and monitor inspection activities of regulated entities according to a schedule.</b></p>	<p><b>Required Documentation 1:</b>          The Military Installation Department of Public Health's protocol(s)/algorithm(s) for scheduling inspections of regulated entities may be located in a military regulation, rule, order, standard operating procedure (SOP), formal agreement (e.g., Memorandum of Understanding (MOU), Memorandum of Agreement (MOA), letter of agreement, or contract).</p> <p>In some cases, schedules for inspections are mandated. In other cases, the schedules for inspections are determined by a risk-based assessment, or the department may have developed its own protocol(s)/algorithm(s) for scheduling inspections. For example, rules requiring dining facility inspections on a specified schedule, or a schedule for return inspections after a violation, may be set forth by another agency, department, or chain of command, as outlined in a regulation, rule, order, standard operating procedure (SOP) or similar information.</p> <p>If the Military Installation Department of Public Health is not mandated to conduct any inspections, that fact will be indicated to PHAB, and <b>no</b> documentation is needed for this requirement.</p> <p><b>Required Documentation 2:</b>          The Military Installation Department of Public Health could provide a database or log of inspection reports that meet the inspection frequencies, as defined in Required Documentation 1, which could be based on rules requiring dining facility inspections or Child Development Services inspections on a specified schedule, or a schedule for return inspections after a violation. The database or log may be an Enterprise system such as the Defense Occupational and Environmental Health Readiness System (DOEHRS) (Environmental Health (-EH) or Industrial Hygiene (-IH). Screenshots or reports pulled from this system that show the log of inspections as required here could be used by Military Installation Departments of Public Health to fulfill this documentation requirement.</p>

	<p>If the Military Installation Department of Public Health is not mandated to conduct any inspections, that fact will be indicated to PHAB, and <b>no</b> documentation is needed for this requirement.</p> <p><b>Documentation Examples:</b>  Military Installation Departments of Public Health could use documentation such as a database screenshot (e.g., DOEHRS-EH, DOEHRS-IH), with fields a–c visible; or multiple screenshots from databases or tools to show all required elements a–c; or tracking logs maintained in a spreadsheet.</p> <p>If the Military Installation Department of Public Health is not mandated to conduct any inspections, that fact will be indicated to PHAB, and <b>no</b> documentation is needed for this requirement.</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 6.1.4 A</b>  <b>Conduct enforcement actions.</b></p> <p><b>Required Documentation 1–4:</b>  <b>For Military Installation Departments of Public Health, this measure is not applicable, and no documentation is needed for these requirements.</b></p>	<p><b>Required Documentation 1–4:</b>  For Military Installation Departments of Public Health, this measure is not applicable, and <b>no</b> documentation is needed for these requirements.</p>
<p><b>Measure 6.1.5 A</b>  <b>Coordinate notification of enforcement actions among appropriate agencies.</b></p> <p><b>Required Documentation 1–2:</b>  <b>For Military Installation Departments of Public Health, this measure is not applicable, and no documentation is needed for these requirements.</b></p>	<p><b>Required Documentation 1 and 2:</b>  For Military Installation Departments of Public Health, this measure is not applicable, and <b>no</b> documentation is needed for these requirements.</p>
<p><b>Measure 6.1.6 A</b></p>	<p><b>Required Documentation 1 and 2:</b>  Military Installation Departments of Public Health do not have enforcement authority for any laws or regulations; however, each health department must have protocols in place that describe how the department shares information with the public about</p>

<p><b>Inform the public about enforcement activities.</b></p>	<p>enforcement activities (e.g., inspection results, product or food recalls, or facility closures) of other agencies (e.g., installation/garrison commander, senior installation commander/senior responsible official, Army and Air Force Exchange Service (AAFES)). The health department may have one overarching protocol or separate protocols for different programs/areas.</p>
<p><b>Measure 6.1.7 A</b>  <b>Identify and implement improvement opportunities to increase compliance.</b></p> <p><b>Required Documentation 1:</b>  <b>If the Military Installation Department of Public Health only performs inspections, the examples will reflect how the installation assessed inspection programs, changed its procedures, or other actions taken to improve compliance; and communicated with the public on the purpose of public health regulations, as part of enforcement activities.</b></p> <p><b>If the health department operates an inspection program that is currently out of compliance with local state, Federal law, or military regulations, then one of the examples must be from that program.</b></p> <p><b>If the health department is</b></p>	<p>For the purposes of this measure, mandated inspections (e.g., food service facility inspections, Child and Youth Services (CYS) and childcare facilities inspections, worksite noise and other exposure sampling, investigating nuisance or pest complaints) are considered an enforcement <b>activity</b>. Military Installation Departments of Public Health typically perform inspections but do not have enforcement <b>authority</b>; therefore, examples for all requirements in this measure must reflect how the health department assessed inspection programs in its areas of responsibility (e.g., worksite inspections, dining facility inspections, etc.), changed its procedures or took other actions to improve compliance, and communicated with the public on the purpose of public health regulations.</p> <p><b>Required Documentation 1:</b>  Documentation of assessing inspection programs might include, for example, a summary or notes of discussion during staff or team meetings; a summary report, memorandum, or Information Paper (IP); briefing slides; a Memorandum for Record (MFR); or other formal or informal evaluations on compliance or process improvements to inspection protocols or procedures.</p> <p><b>For required element a:</b>  The assessment summary could describe, for example, the most common types of <b>inspections</b> conducted by the health department; whether complaints in the areas that the health department inspects are happening more frequently within certain units, neighborhoods, or organizations; or whether compliance with inspection procedures (e.g., Tri-Service Food Code, local standard operating procedures (SOPs) has increased or decreased across a timeframe. Patterns or trends could be related to the outcome of the inspections; types of violations; complaints received; unit or shop focus; unit, shop, or neighborhood location; or other factors.</p> <p>A list of inspections or complaints would <b>not</b> meet the intent of this required element.</p> <p><b>For required elements b and c:</b>  The intent of these required elements is to evaluate the health department's processes (<b>not</b> those of the regulated entity), which could be related to the health department's methods to provide education or inspections to help the regulated entity (e.g., unit, shop, food service facility, Child and Youth Services (CYS) facilities) achieve compliance. Evaluation could identify what parts of the Military Installation Department of Public Health's inspection processes work well and which issues arose with these processes. The intent is <b>not</b> to show what worked well or was problematic for a single inspection or investigation <b>but instead</b> to evaluate the inspection program's activities and processes, based on a review of its patterns or trends.</p> <p><b>For required element d:</b>  For Military Installation Departments of Public Health, recommended changes could relate to, for example, updates to inspection procedures, education or training needs for personnel involved in conducting inspections identified, or opportunities to improve consistency in the application of procedures among staff.</p> <p><b>Required Documentation 2:</b>  Documentation of changes to investigation or inspection procedures or other actions taken to enhance enforcement-related activities to improve compliance could include changing one or more aspects of an inspection or complaint investigation procedure (e.g., for noise, pest complaints, worksite air quality concerns, etc.); launching an education campaign for regulated entities (e.g., food service workers, child development center personnel), based on a pattern of complaints, violations, or non-compliance issues across</p>

<p><b>responsible for only one inspection program, the health department must submit only one example from that program and must indicate in the Documentation Form that the health department is only responsible for the one inspection program.</b></p>	<p>entities; providing new or updated training to regulated entities or personnel to improve compliance in a culturally or linguistically appropriate manner; or changing communication methods to educate the public about the purpose of public health regulations to improve reach.</p> <p><b>Required Documentation 3:</b>  Military Installation Departments of Public Health 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 local school system surrounding the installation community or Department of Defense Education Activity (DoDEA) schools may have the responsibility to ensure that all children entering the respective school's kindergarten have had age-appropriate vaccinations. In this instance, the health department could provide education to the public served on the purpose or importance of immunization laws.</p>
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**Domain 7**

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

PHAB recognizes many of the functions within this domain may be performed at a higher level, such as the Defense Health Agency (DHA) market/network or Medical Treatment Facility (MTF). Military Installation Departments of Public Health may provide documentation developed by broader or umbrella agencies with evidence of the Military Installation Departments of Public Health contributions, such as participation in processes, application, or use.

**STANDARD 7.1**

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

<p><b>Measure 7.1.1 A</b>  <b>Engage with health care delivery system partners to assess access to health care services.</b></p> <p><b>Required Documentation 1:</b>  <b>If the Military Installation Department of Public Health's role is not clear from the assessment, the Documentation Form</b></p>	<p><b>Required Documentation 1:</b>  The Military Installation Department of Public Health does <b>not</b> need to have conducted the assessment of access to health care which could be conducted at a higher level, such as at the applicable Medical Treatment Facility (MTF), at the Defense Health Agency (DHA) market/ network level, or if working with non-military partners at a city, county, or regional level. <b>However</b>, the intent of the requirement is that the Military Installation Department of Public Health plays a role as a participant to develop or contribute towards the assessment, or that the Military Installation Department of Public Health has reviewed or considered the results of the assessment to understand the needs of the population served, as well as the assessment's use in planning. For example, the collaborative assessment could focus on the utilization of health care services, given the access to health care services afforded to the population served by the Military Installation Department of Public Health, even if the assessment was conducted at a DHA or DHA market/network level. The Military Installation Department of Public Health could, for example, describe how it contributed towards the assessment, helped interpret the results, or used the results, for example, as part of its efforts to improve utilization or coordination of care.</p> <p>The collaborative assessment may be part of the community health assessment or a separate assessment. Multiple assessments may be provided to address one or multiple required elements, as appropriate.</p>
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may be used to indicate the Military Installation Department of Public Health's role (as a participant or contributor) or how the Military Installation Department of Public Health reviewed or considered the results of the assessment for each required element, as appropriate.

**For required element a:**

The collaborative process may be embedded within the Medical Treatment Facility (MTF), Defense Health Agency (DHA) market/network, or broader community on- or off-post, as long as the focus includes the population served by the Military Installation Department of Public Health. In addition to engaging primary care and behavioral health providers, the collaborative process might also engage on-post or off-post partners (or combination), including, but not limited to, the supporting MTF and/or neighboring health care system(s); the DHA market/network; representatives of multiple disciplines, such as other medical care providers, social services, nutritional counselors or specialists, and dentists or hygienists; and other units or partners involved in addressing or coordinating access to care or service utilization.

The collaborative assessment addresses the utilization of health care services for planning purposes and could also focus on topics or the access needs of un-/underserved groups or individuals at higher health risks (e.g., women's health). The process, along with a list of partners involved (e.g., coalition/network/council members) may be facilitated by the MTF's Clinical Operations Division, Care Utilization Department and/or Population Health Department, or the DHA Market/Network Optimization Team (MOT). The list of partners involved in the collaborative assessment may be stand-alone, contained in a report, or found in related meeting agendas or meeting minutes, for example.

**For required element b:**

Data on populations who experience barriers or lack of access to care may be obtained, for example, from an assessment survey and/or surveys of particular population groups; a review of measures such as the Healthcare Effectiveness Data Information Set (HEDIS) to assess health care service utilization; or meeting minutes or reports determining the need and/or impact of a Patient-Centered Medical Home (PCMH) or community-based medical homes; or different Medical Treatment Facilities (MTFs) or services within a Defense Health Agency (DHA) market/network. Other information sources include analyses of secondary data and/or health care data, such as emergency department admissions, population insurance status data, or other sources, for example, assessing access to contraceptive care by examining data from the Department of Defense (DoD) Contraceptive Program or Deployed Prescription Program (DPP), or results from the Women's Reproductive Health Survey (WRHS), or other data.

Other considerations might address, for example, how system(s) of care may not be well designed to serve populations based on, for example, age (e.g., teenagers, elderly, etc.), ethnicity, geographic location, transportation (e.g., one-car households), sexual orientation (e.g. LGBTQ+ populations), military affiliation, highest educational level attained, mental or physical disabilities, discrimination (e.g., marriage inequality), other service needs (e.g., navigating parenthood while serving; balancing care for families while meeting military requirements or responsibilities; service members experiencing pregnancy and postpartum; individuals with diabetes, etc.; or populations who do not trust health care providers), stigma related to accessing care, or a population's lack of understanding about why certain routine medical services or screenings are necessary to protect their health.

Barriers to health care may include, but are not limited to, long wait times, lack of childcare during health care visits, lack of transportation to health care, fear of accessing particular services due to potential negative impacts on the service member's military career, cultural barriers, financial barriers to accessing vision or dental care for beneficiaries, etc.

**For required element c:**

The Military Installation Department of Public Health's or partnership's review of data on the availability of and gaps in services might consider, for example, the availability or utilization of health care services such as clinical preventive services, Emergency Medical Services (EMS), emergency departments, urgent care, occupational medicine, ambulatory care (primary and specialty), inpatient care, chronic disease care (e.g., diabetic care, human immunodeficiency virus (HIV) health services), dental care, behavioral health

	<p>care, and other health care services. The assessment might include, for example, Medical Treatment Facility (MTF) clinical operations; population health or managed care data that identify the availability or utilization of services and gaps in services; Healthcare Effectiveness Data Information Set (HEDIS) measures from the MTF or the Defense Health Agency (DHA) market/network; or vaccination rates for active-duty military personnel and/or eligible beneficiaries. Assessment of services could also include, for example, the capacity and geographic distribution of providers (e.g., patient/provider ratios within the MTF or referral networks; or providers accepting new clients); or services that are not widely available (e.g., services with long wait times for appointments, or areas within the jurisdiction with limited or no providers in general or within a specific specialty). Data used in the analysis may include secondary sources, such as TRICARE, DHA, or DHA market/network data.</p> <p><b>For required element d:</b> Conclusions may be drawn, for example, from various partnership sources such as the Medical Treatment Facility's (MTF's) clinical operations; population health, utilization, or managed care data; Defense Health Agency (DHA), DHA market/network, or TRICARE data that identify and describe gaps in utilization of, access to, and barriers to health care services; or any of the data used in the assessment as documented for required elements b and c. Conclusions should be based on analysis of data and can help develop effective strategies to ultimately address gaps in health care utilization or access.</p>
<p><b>Measure 7.1.2 A</b> <b>Implement and evaluate strategies to improve access to health care services.</b></p>	<p><b>Required Documentation 1:</b> The Military Installation Department of Public Health does not need to have convened or led the collaborative process, but the department's role will be indicated to show how the department participated in implementing strategies. In addition to the examples provided in <i>The Standards</i>, the collaboration could include working with community coalitions or collaboratives (e.g., Commander's Ready and Resilient Councils (CR2Cs)), working groups, patient advocacy groups, or others.</p> <p>Examples could also include documentation that indicates the Military Installation Department of Public Health's role in the following:</p> <ul style="list-style-type: none"> <li>• Documented referral system between two or more Medical Treatment Facility (MTF) departments; the Military Installation Department of Public Health's services and one or more MTF departments; or with the MTF or Military Installation Department of Public Health and providers in the network or off-post community that shows the methods used to link individuals with needed health care services.</li> <li>• Documented referral system between the MTF contraceptive clinic and sexually transmitted infection (STI) clinic.</li> <li>• Coordinated and integrated behavioral, public health, and primary care services.</li> <li>• Documented referral system between Women, Infants, and Children (WIC) and service providers, such as pediatric clinics. (Note that a referral system to social service providers would not meet the intent of the measure, as collaborating with other sectors to improve access to social services is covered under Measure 7.2.1 A.)</li> <li>• Collaboration with behavioral health and tactical/mission units on a campaign to reduce stigma associated with seeking behavioral health services.</li> <li>• Increase in the availability or methods to access timely care through telehealth services or other mechanisms.</li> <li>• Transportation mechanisms or coordination of services, for example, for individuals who are homebound or in a single-car household.</li> <li>• Arrangements for child care for patients to enhance service utilization.</li> <li>• After-hours or weekend clinics for women's health or children's health.</li> </ul> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, evaluation feedback gathered from patient populations who were the focus of the strategy might include, for example, Interactive Customer Evaluation (ICE), Joint Outpatient Experience Survey (JOES),</p>

	<p>TRICARE Inpatient Satisfaction Survey (TRISS), or other data collected directly from patient population(s) who were the focus of the strategy. The feedback collected from individuals is <b>not</b> required and may be summarized to show the results of the evaluation. The Documentation Form may be used to describe who participated in the evaluation. The evaluation does <b>not</b> need to be complex, formal, or costly and could focus on a variety of topics, for example, costs, timeliness or availability of appointments, increased service utilization, or improved health status or outcomes, etc.</p>
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## STANDARD 7.2

### Connect the population to services that support the whole person.

<p><b>Foundational Capability Measure</b></p>	<p><b>Required Documentation 1:</b></p>
<p><b>Measure 7.2.1 A</b> <b>Collaborate with other sectors to improve access to social services.</b></p>	<p>The examples need not be formal but should be intentional and ongoing (not be a one-time discussion). Military Installation Departments of Public Health might consider, for example, strategies implemented by bringing together stakeholders during community coalition or collaborative (e.g., Commander’s Ready and Resilient Council (CR2C)) meetings in order to improve access to social services such as—</p> <ul style="list-style-type: none"> <li>• Co-location of social services in a convenient location, for example, social service aspects of WIC services near the host installation or at the Medical Treatment Facility (MTF).</li> <li>• Referral systems from primary care or behavioral health to Army Community Service (ACS) programs such as the Financial Readiness Program (FRP), Family Advocacy Program (FAP), the installation chaplain, Employment Readiness Program, Relocation Readiness, or referrals to off-post social services, on- or off-post domestic violence prevention or response programs, etc.</li> <li>• Coordinated service delivery or co-location of services in a convenient location (e.g., installation, unit, or Medical Treatment Facility (MTF) Sexual Harassment/Assault Response and Prevention (SHARP) Program or staff, or Armed Forces Wellness Centers (AFWCs).</li> <li>• Integration of behavioral or social service questions into screenings.</li> </ul>
<p><b>Measure 7.2.2 A</b> <b>Collaborate with other sectors to ensure access to care during service disruptions.</b></p>	<p><b>Required Documentation 1:</b></p> <p>Strategies within the military setting may include working with partners on and/or off post to ensure military beneficiaries obtain care or social services in the event of service disruption. This collaboration could include establishing systems of care with other Medical Treatment Facilities (MTFs); within a Defense Health Agency (DHA) market/network or across DHA markets/networks; with local, off-post and civilian health care or social service partners; or with on-post service agencies such as the MTF, Army Community Service (ACS); tactical/mission units; or others. It may also involve the American Red Cross, the National Guard, or other agencies that provide assistance during such events.</p> <p>Additional documentation could include, for example, the MTF or installation Emergency Operations Plan (EOP) or a related annex showing the involvement of the Military Department of Public Health or its personnel, including, but not limited to, the Public Health Emergency Officer (PHEO) or Assistant PHEO (APHEO).</p>

## Domain 8

### Build and support a diverse and skilled public health workforce.



## STANDARD 8.1

### Encourage the development and recruitment of qualified public health workers.

<b>Measure 8.1.1 T/L</b> <b>Collaborate to promote the development of future public health workers.</b>	<p><b>Required Documentation 1:</b></p> <p>In addition to <i>The Standards'</i> examples of collaborative activities to promote public health careers, Military Installation Departments of Public Health may also provide such examples as practicum placements/academic service learning opportunities for students within the health department; collaborating with recruiting units to talk with new active-duty service member candidates about military public health careers; coordinating with the applicable training commands, units, or schools, such as the U.S. Army Medical Center of Excellence (MEDCoE) to promote public health as a career field to students; or having Military Installation Department of Public Health personnel provide public health career guest lectures/events in military or civilian community or educational settings. These collaborative activities or guest lectures could take place in elementary, middle, or high schools; or continuing education/higher-education settings.</p>
<b>Foundational Capability Measure</b> <b>Measure 8.1.2 A</b> <b>Recruit a qualified and diverse health department workforce.</b>	<p>Military Installation Departments of Public Health may select two examples of civilian personnel recruitment or hiring efforts aimed at securing a qualified and diverse workforce. When recruitment functions are performed outside of the Military Installation Department of Public Health, documentation for this measure may require collaboration with the human resources office of the Military Installation Department of Public Health's supporting organization (e.g., the Medical Treatment Facility (MTF)). It may include supporting documentation from higher Military commands; agencies such as the Defense Health Agency (DHA); Department of Defense (DoD); Civilian Human Resources Agencies (CHRA); Civilian Personnel Advisory Center (CPAC); or the U.S. Office of Personnel Management (OPM).</p> <p>In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health may deploy a variety of strategies to recruit or hire a qualified and diverse workforce. For example, the Military Installation Department of Public Health could encourage a diverse pool of applicants by leveraging relationships with community or other organizations. Collaborative relationships may be with on- or off-post organizations and may involve formal or informal relationships to facilitate recruitment for Military Installation Department of Public Health positions.</p> <p>Methods to secure a qualified workforce might include, for example, working across the military enterprise, as well as with community organizations or colleges, universities, or trade schools to recruit competent candidates. Examples include recruitment during hands-on learning or lectures, or participating in career fairs that focus on public health as well as competencies or training requirements for specific positions within the Military Installation Department of Public Health such as epidemiologist, public health nursing, environmental health, industrial hygiene, emergency preparedness, health promotion, etc.</p> <p>In addition to the documentation examples listed in <i>The Standards</i>, Military Installation Departments of Public Health may use Veteran's Preference and Military Spouse Preference hiring policies, or job postings or position descriptions that specify these preferences are given for a particular position dated within the past 5 years if fewer than two opportunities to recruit or hire for a position have occurred within the last 5 years.</p>

## STANDARD 8.2

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

<b>Foundational Capability Measure</b>	<p><b>Required Documentation 1:</b></p> <p><b>For required element a:</b></p>
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**Measure 8.2.1 A**  
**Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.**

For Military Installation Departments of Public Health, the description of the current capacity of the department could also include a breakdown of staff by military affiliation (e.g., active-duty, Defense Health Agency (DHA) civilian or contractor) or primary professional credentials (e.g., audiology tech, environmental health tech, epidemiology tech, industrial hygiene tech, registered nurse, registered sanitarian, etc.) to examine whether the Military Installation Department of Public Health has the number of staff needed in appropriate roles to meet the needs of the population it serves. It is **not** necessary that the capacity assessment be in-depth about each department sub-unit (e.g., section); identification of which sub-units are experiencing the largest capacity gaps, or a focus on only one or two sub-units (e.g., environmental health, industrial hygiene, occupational health, etc.) would meet the intent to demonstrate an assessment of current capacity.

**For required element b:**

In addition to the Council on Linkages between Academia and Public Health Practice core competency assessment, various other assessments could be considered, such as those developed by a state health department, military service department or its medical department, or Department of Defense (DoD)-developed or specialty-focused sets of competencies, for example, nursing, public health preparedness, and informatics competencies.

**For required element c:**

In addition to the equity assessments provided in **The Standards**, Military Installation Departments of Public Health might also consider engaging Medical Treatment Facility (MTF), Defense Health Agency (DHA) markets/networks or headquarters, or military service department-specific programs or tools (e.g., the Army's Equity and Inclusion Agency), or others, as appropriate, in the assessment of workforce competences related to equity.

**For required element d:**

For Military Installation Departments of Public Health, gaps for prioritization (based on required elements a–c) could be related to, for example, cultural competency or diversity, equity, and inclusion; quality improvement and performance management training needs; community engagement; evidence-based decision-making; or gaps in capacity or capability in other areas. Prioritization of identified gaps in the existing workforce's capacity based on results of the assessments in required elements a–c) may involve comparisons, for example, between the military and civilian personnel, or across department sub-units, tiers of positions (e.g., management vs. non-management), or other variables.

**For required element e:**

The Military Installation Department of Public Health's plans could be developed based on gaps identified that are specific to either military or civilian workforce development needs, needs of a specific tier of personnel (e.g., non-managerial vs. managerial staff), or the health department as a whole. For example, while the military and civilian personnel may have similar workforce training objectives, there may be differences in training philosophies for service members that are focused on personal readiness and military operational training versus training philosophies for civilian employees. Military leaders' focus for military personnel may center on training strategies to ensure service member readiness in support of deployment capability, ensuring every service member is physically and cognitively ready and proficient in their respective operational skills to support the essential tasks, etc., which may differ from civilian workforce objectives, improvement strategies, or activities. The Military Installation Department of Public Health may choose to delineate plans specific to military versus civilian personnel **or** develop strategies that address both.

**Required Documentation 2:**

The list of learning or educational opportunities that relate to gaps in capacity or capabilities address the workforce of the installation, as a whole, inclusive of its military and civilian workforce development needs. For example, while the military and civilian personnel

	<p>may have similar workforce training objectives, there may be differences in training philosophies between individual service member readiness and training needs. Military leaders' focus for military personnel may center on training strategies to ensure military readiness in support of deployment capability, ensuring every service member is physically and cognitively ready and proficient in their respective critical medical wartime skills to support the essential tasks, etc., which may differ from civilian workforce objectives or improvement strategies or activities. The Military Installation Department of Public Health may choose to delineate plans, specific training or learning opportunities by military versus civilian members of its workforce <b>or</b> develop separate lists of learning or educational opportunities to address the unique needs of both; however, the list of learning or educational opportunities must comprehensively cover the entire non-contractor workforce of the Military Installation Department of Public Health.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 8.2.2 A</b> <b>Provide professional and career development opportunities for all staff.</b></p>	<p><b><u>For Required Documentation 1:</u></b> In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health might consider examples of annual Individual Development Plans (IDPs), Officer Evaluation Reports (OERs), Non-commissioned Officer Evaluation Reports (NCOERs), or other individualized professional development plans for non-managerial staff showing progress toward completion.</p> <p>Professional development activities within the Military Installation Department of Public Health context might include, for example, allowing for time off for classes (e.g., administrative leave for civilian personnel or permissive temporary duty (TDY) or a pass for military personnel), on-duty participation in classes offered by military schools or agencies, such as the U.S. Army Management Staff College, U.S. Army Medical Center of Excellence (MEDCoE), Defense Health Agency Public Health (DHA Public Health)/ a Defense Center for Public Health (DCPH); continuing education; local and regional training opportunities; mentoring; etc. Topics could include, for example, emergency response, data visualization methods, health equity, communications, and courses required for continuing education credits. Trainings or classes focused on leadership, management, or supervisory skills among staff in <u>managerial positions</u> would <b>not</b> meet the intent, but training on leadership, management, or supervisory skills among <u>non-managerial</u> staff, for example, to promote professional development or as part of succession planning could be provided.</p> <p>In addition to the documentation examples to demonstrate evidence of completion of a training or learning opportunity specified in <i>The Standards</i>, Military Installation Departments of Public Health could use a completed and fully signed SF-182 or email message showing approval of participation in the training or time off granted to attend courses or trainings, or support for membership in a professional association.</p> <p><b><u>For Required Documentation 2:</u></b> In addition to the examples provided within <i>The Standards</i>, Military Installation Departments of Public Health' participation in leadership or management development opportunities could include, for example, attending trainings provided by military-specific schools or agencies, including, but not limited to, the U.S. Army Medical Center of Excellence (MEDCoE), U.S. Army Management Staff College, Non-Commissioned Officer Leadership Center of Excellence (the latter at the installation/garrison), and could include standard military education (e.g., Captain's Career Course, Intermediate Level Education (ILE), Basic Leader Course), Civilian Education System (CES) or similar trainings, executive management seminars or programs, graduate programs in leadership/management, and related meetings and conferences. Topics of learning opportunities could include, for example, negotiation skills, continuous process improvement, systems thinking, officer professional development, public health leadership, change management, intercultural or intergenerational management, collaborative intelligence, handling conflict, coaching and mentoring skills, diversity/cultural awareness, communications skills for managers, leadership styles, effective networks, concepts of public health informatics, leading teams and collaborations, health equity, community resilience, relationship building, marketing/branding, business process improvement, digital media, and crisis/risk communication. The leadership or management</p>

	<p>training does <b>not</b> need to be public health-focused. It <b>does</b> need to be focused on leadership or management skills and cannot be focused solely on military strategy.</p>
<p><b>Measure 8.2.3 A</b> <b>Build a supportive work environment.</b></p> <p><b><u>Required Documentation 1:</u></b> <b>The Military Installation Department of Public Health’s policy or set of policies must cover methods to build a supportive work environment for the entire workforce, inclusive of both military and civilian personnel (for required elements a–d).</b></p>	<p><b><u>Required Documentation 1:</u></b> The intent of this requirement is to provide policies that go above and beyond state and federal laws to build a supportive work environment for staff. Documentation for this measure may require collaboration with the human resources office of the Military Installation Department of Public Health’s supporting organization (e.g., the Medical Treatment Facility (MTF)). Supporting documentation may include that from higher level agencies (e.g., Defense Health Agency (DHA); Department of Defense (DoD)), military commands, or from Federal agencies such as the U.S. Office of Personnel Management (OPM).</p> <p><b>For required element a:</b> Worksite health and wellness programs help employees modify their lifestyles and move toward an optimal state of wellness. They can produce organizational and employee benefits, such as lowered healthcare costs, increased productivity, improved recruitment and retention, reduced absenteeism, and enhanced employee engagement. Worksite health and wellness interventions include, but are not limited to, ergonomic support (e.g., standing desks), health education, nutrition services, lactation support, physical activity promotion, health screenings, vaccinations, traditional occupational health and safety, disease management, and linkages to related employee services. Examples include Armed Forces Wellness Centers (AFWCs/AWCs), agency civilian fitness policies, and special wellness events or services offered to military and/or civilian employees.</p> <p><b>For required element b:</b> For Military Installation Departments of Public Health, work/life balance may also support leave and pass processes affording flexibility in the types of leave, or assignment accommodations for dual-military couples through a Married Couples Program. Work-life balance policies could also address the needs of active-duty single parents balancing caring for their families while meeting service member requirements or work expectations; aspects of a family care plan; pregnancy, pregnancy loss, or postpartum support; telework; alternative work schedules; family, paternity, or maternity leave; breastfeeding/lactation support; etc.</p> <p><b>For required element c:</b> Examples can address both team and individual recognition and recognition for employee improvement. Examples of employee recognition include an employee-of-the-month program, posting an employee honor roll, a cash or time-off/pass award program (for civilian and military personnel, respectively), recognition certificates or letters, regularly organized recognition ceremonies, and applicable agency- or military service department-specific awards, etc.</p> <p><b><u>Required Documentation 2:</u></b> In addition to the examples within <b>The Standards</b>, the Military Installation Department of Public Health could demonstrate efforts to assess staff satisfaction and actions taken in tandem with the Armed Forces Wellness Center (AFWC), Medical Treatment Facility (MTF), or from higher Military commands, agencies such as the Defense Health Agency (DHA) or Department of Defense (DoD), or Federal agencies such as the U.S. Office of Personnel Management (OPM). If the assessment process and/or actions taken are performed at a broader level, the results and actions must pertain to the workforce of the Military Installation Department of Public Health.</p> <p><b>For required element a:</b> In addition to the methods described within <b>The Standards</b>, for Military Installation Departments of Public Health, the systematic collection of feedback from staff might involve command climate assessments or sensing sessions with personnel. A staff suggestion</p>

box, such as Interactive Customer Evaluation (ICE) comments, or any other passive method of collecting staff feedback, would **not** meet the intent of conducting an assessment.

**For required element b:**

In addition to the examples provided within *The Standards*, drawing conclusions could include identifying themes, such as opportunities to develop, expand, or improve worksite health and wellness programs; improve the telework or alternative work schedule policies; offer flexible types of leave or accommodations for personnel who have experienced a work-related move or permanent change of station; etc. Other types of documentation examples for Military Installation Departments of Public Health beyond those listed in *The Standards* may include an Information Paper (IP) or a summary report in the form of a memorandum, briefing slides, or technical report.

**For required element c:**

In addition to the examples provided within *The Standards*, actions taken based on conclusions drawn from the staff satisfaction assessment could relate to providing input to improve or support the workforce to a broader agency, higher headquarters HQ, or umbrella agency, such as efforts taken by the Office of Personnel Management (OPM), Defense Health Agency (DHA), Department of Defense (DoD), or Medical Treatment Facility (MTF) to support work-life balance, employee recognition, wellness, or staff inclusion. For Military Installation Departments of Public Health, examples could relate to supporting work/life balance, for example, supporting leave and pass processes (e.g., affording flexibility in the types of leave, or accommodations for personnel who have experienced a work-related move or permanent change of station), including, but not limited to, dual-military couples; addressing the needs of service members who are single parents balancing caring for their families while meeting military requirements or work expectations; developing family care plans; providing pregnancy, pregnancy loss, or postpartum support; offering telework, alternative work schedules, family or paternity or maternity leave, and breastfeeding/lactation support; etc.

Other actions taken based on conclusions drawn from assessing staff satisfaction might relate to worksite health and wellness offerings. For example, the Military Installation Department of Public Health might work with the Armed Forces Wellness Center (AFWC) or others to host special events or services for military and/or civilian employees. The Military Installation Department of Public Health could also consider offering health and wellness interventions, such as ergonomic support (e.g., standing desks), health education, nutrition services, lactation support, physical activity promotion, or linkages to related employee services.

## 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.

PHAB defines performance management as a systematic process which helps an organization (rather than an individual employee performance appraisal) achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results (Public Health Foundation (PHF). Focus Areas: Performance Management. "Overview". Accessed on June 21, 2021).

<p><b>Foundational Capability Measure</b></p>	<p><b>Required Documentation 1:</b>  The intent of this measure is to assess the Military Installation Department of Public Health’s adoption of a department-wide performance management system. In the military setting, use of the supporting organization’s performance management system (e.g., CarePoint, Strategic Management System, or related systems like the Army Public Health Management System) to achieve this measure would be acceptable as long as it includes the Military Installation Department of Public Health’s scope of practice.</p> <p>*Note: Documentation for this requirement may be similar in intent or the same as that used for Medical Treatment Facility (MTF) health care accreditation. If applicable, coordinate with appropriate entities within the MTF to identify whether the health care accreditation documentation may also apply to and/or support this public health accreditation requirement. It should be noted, however, that documentation assessed as acceptable by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p><b>For required element a:</b>  For Military Installation Departments of Public Health, goals or objectives may be administrative or programmatic. Administrative goals or objectives might include, for example, processing requests for information, inspection report submissions, staff professional development, and workforce development. Examples of programmatic areas where performance management might be appropriate include achievement of program-level goals for industrial hygiene staff completion of worksite visits, and the timely completion of site inspections by public health nurse and environmental health staff. Documentation might include, for example, information provided in narrative, table, or graphic form, or screenshots from applicable systems such as the Strategic Management System (SMS) and could include documented measures of effectiveness (MOEs) or measures of performance (MOPs).</p>
<p><b>Measure 9.1.1 A</b>  <b>Establish a performance management system.</b></p>	<p><b>Required Documentation 1:</b>  <b>For required element b:</b>  In addition to the guidance within <i>The Standards</i>, the Military Installation Department of Public Health might consider customer feedback collected through forms, surveys, focus groups, or department comment cards (e.g., Interactive Customer Evaluation (ICE) comments). Data collected for other purposes (e.g., ICE comments used to gather feedback) may be used if tied to the Military Installation Department of Public Health’s performance management system to show performance management system implementation (e.g., as part of a quality improvement project). The example may relate to any external customers served by the Military Installation Department of Public Health, such as tenant organizations on the installation, food establishment operators or staff, health care beneficiaries enrolled at the Medical Treatment Facility (MTF), or others. If tied to an administrative goal, the customers could also be internal to the Military Installation Department of Public Health (e.g., department staff/leadership, etc.).</p> <p><b>For required element c:</b>  In addition to the examples provided within <i>The Standards</i>, tracking of progress towards achieving objectives could include, for example, information provided in narrative form (e.g., a progress summary, report, or description) or in table(s), spreadsheet(s), chart(s), or graphic(s); or in screenshots from applicable systems such as Public Health Management System (PHMS), CarePoint, or the Strategic Management System (SMS).</p>
<p><b>Measure 9.1.2 A</b>  <b>Implement the performance management system.</b></p>	<p><b>Required Documentation 1:</b>  For Military Installation Departments of Public Health, customers or stakeholders may include, for example, tenant organizations on the installation, food establishment operators or staff, mass vaccination event clients, or healthcare beneficiaries enrolled at the Medical Treatment Facility (MTF). Data collection methods or instruments for collecting customer/stakeholder satisfaction might include, for example, forms, surveys, focus groups, or departmental comment cards.</p> <p><b>For required element a:</b></p>
<p><b>Measure 9.1.3 A</b>  <b>Implement a systematic process for assessing customer satisfaction with health department services.</b></p>	<p><b>Required Documentation 1:</b>  For Military Installation Departments of Public Health, customers or stakeholders may include, for example, tenant organizations on the installation, food establishment operators or staff, mass vaccination event clients, or healthcare beneficiaries enrolled at the Medical Treatment Facility (MTF). Data collection methods or instruments for collecting customer/stakeholder satisfaction might include, for example, forms, surveys, focus groups, or departmental comment cards.</p> <p><b>For required element a:</b></p>

	<p>In addition to the examples specified in <b>The Standards</b>, special efforts in the design and execution of data collection at Military Installation Departments of Public Health could include, for example, purposely focusing on eliciting feedback from groups in the installation community that are disproportionately affected by health issues, higher health risks, or poorer health outcomes. In the population served by the Military Installation Department of Public Health, these groups may include communities of color, junior enlisted service members and their families, service members who have recently deployed, family members of those who are currently deployed, communities of color, those enrolled in the Exceptional Family Member Program (EFMP), hearing or visually impaired individuals, those with disabilities, or LGBTQ+ individuals.</p> <p><b>For required element b:</b> For Military Installation Departments of Public Health, documentation could also include, for example, an Information Paper (IP) or briefing.</p> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, documentation examples could also include an Information Paper (IP), Executive Summary (EXSUM), or After Action Review (AAR).</p>
<p><b>Measure 9.1.6 A</b> <b>Promote a culture of quality by engaging staff at all organizational levels in performance management and quality improvement.</b></p>	<p><b>Required Documentation 2:</b> <b>For required element b:</b> The team facilitating continuous quality improvement (QI) at Military Installation Departments of Public Health, could be that of the umbrella organization to which the department belongs (e.g., Medical Treatment Facility (MTF)), as long as public health QI is incorporated into the team’s efforts, training opportunities, etc.</p> <p><b>Required Documentation 3:</b> In addition to the guidance provided in <b>The Standards</b>, Military Installation Departments of Public Health may consider whom to include from leadership, for example, the Chief, Department of Public Health (DPH); the Deputy Chief, DPH; and/or one or more section chiefs (e.g., Chief, Public Health Nursing; Chief, Environmental Health).</p>

<p style="text-align: center;"><b>STANDARD 9.2</b> <b>Use and contribute to developing research, evidence, practice-based insights, and other forms of information for decision making.</b></p>	
<p><b>Foundational Capability Measure</b> <b>Measure 9.2.1 A</b> <b>Identify and use applicable research and practice-based information for program development and implementation.</b></p>	<p><b>Required Documentation 1:</b> <b>For required element a:</b> In addition to the examples provided within <b>The Standards</b>, the source of research or practice-based information might also include evidence-based or promising practices from military-specific sources such as the Defense Health Agency-Public Health (DHA Public Health)/ a Defense Center for Public Health (DCPH), military service medical department (e.g., U.S. Army Medical Command (MEDCOM), Defense Health Agency (DHA), a military medical research agency (e.g., Walter Reed Army Institute of Research (WRAIR) or U.S. Army Institute of Environmental Medicine (USARIEM)), or other Military Installation Departments of Public Health.</p> <p><b>For required element b:</b> If the Military Installation Department of Public Health has not customized any evidence-based or promising practices during the timeframe, an example of an evidence-based or promising practice that was implemented without customization and a narrative describing the general process for tailoring evidence-based or promising practices to the community could be provided. Examples of</p>

	<p>adopting evidence-based or promising practices customized to be appropriate for the community and the community’s particular characteristics for Military Installation Departments of Public Health could be, for example, customizing an evidence-based or promising practice focused on weight loss within Armed Forces Wellness Center (AFWC) as part of medical readiness, tailoring evidence-based practices or promising practices on heat illness within occupational or injury prevention health educational materials or protocols, or tailoring mold abatement evidence-based practices to prevent health hazards, such as asthma, within congregate or other on-post housing units. In addition to the documentation examples listed in <b>The Standards</b>, the Military Department of Public Health could also provide, for example, a program description from an Information Paper (IP) or website (screenshots), promotional material, an operations order (OPORD), or briefing slides, etc.</p> <p>Changes made to Enterprise-wide programs based on evidence or research that are then directed to be enacted at the Military Installation Department of Public Health or with its partners, and where the department did not have direct influence on the changes, are <b>not</b> acceptable examples. The examples for Military Installation Departments of Public Health must be those policies, programs, processes or interventions that the department has an ability to influence directly. The Military Installation Department of Public Health could, however, provide examples of working with community or other partners (e.g., Commander’s Ready and Resilient Councils (CR2Cs)) to identify and use applicable research or practice-based information for program development and implementation. For example, the department might work with Community Health Improvement Plan (CHIP), coalition or working group (e.g., CR2C) members, or other community partners to identify research or practice-based evidence from peer-reviewed journals, peer health departments, or other sources on ways to increase breastfeeding rates, healthy or nutritious food options, blood pressure screening, etc. The department might use the research or practice-based information identified to update or develop new processes, programs, or interventions, considering a particular group or the community served.</p> <p><b>For required element c:</b> Because there may be limited availability of researched or practice-based evidence specific to military communities, Military Installation Departments of Public Health could provide documentation of how research or practice-based evidence in other communities has been adapted to integrate the military culture, values, priorities, and terminology.</p>
<p><b>Measure 9.2.2 A</b> <b>Evaluate programs, processes, or interventions.</b></p>	<p><b>Required Documentation 1:</b> The evaluation could be conducted by the Military Installation Department of Public Health or by other entities, such as local universities (e.g., as part of student projects), civilian or military partner organizations, such as the Defense Health Agency-Public Health (DHA Public Health)/a Defense Center for Public Health (DCPH). The evaluation does not need to be formal but would demonstrate structured collection of data or a systematic or standardized approach. Data used to inform the improvement are not required but might include, for example, feedback collected during sensing sessions, townhalls, focus groups, or surveys.</p>
<p><b>Measure 9.2.3 A</b> <b>Communicate research findings, including public health implications.</b></p>	<p><b>Required Documentation 1:</b> <b>For required element a:</b> In addition to the examples provided within <b>The Standards</b>, the source of the research used by the Military Installation Department of Public Health could include military-specific sources, such as the Defense Health Agency (DHA), DHA Public Health /a Defense Center for Public Health (DCPH), a military service medical department (e.g., US Army Medical Command (MEDCOM)), or other military research institution such as the Walter Reed Army Institute of Research (WRAIR) or U.S. Army Institute of Environmental Medicine (USARIEM). Research in this context is characterized as peer-reviewed, validated by experts (e.g., as an advisory board or expert review panel), or having undergone an expert technical review.</p> <p><b>For required element b:</b> In addition to the examples provided within <b>The Standards</b>, the Military Installation Department of Public Health could explain how the research might influence current or future public health interventions or practice, for example, the delivery or reach of services or</p>



	<p>impact of a policy on health behaviors, military readiness or resilience, health outcomes, or equity. The implications of research could also relate to public health-related operations, resource allocation, or partnerships.</p> <p><b>For required public health c:</b>  The Military Installation Department of Public Health may engage with a wide range of <b>external</b> stakeholders about public health implications of research including, for example, community coalitions or collaboratives (e.g., Commander’s Ready and Resilient Council (CR2C)), integrated prevention workforce personnel, health care providers, tactical units, veterinarians, installation/garrison or mission command teams, community service groups (e.g., spouses’ club), local schools (on- or off-installation), other public health stakeholders, partners, or groups of the public served by the Military Installation Department of Public Health. Examples may also reflect communicating implications to the governing entity, defined as the commander or command team (e.g., Medical Treatment Facility (MTF) commander) or other designated commander or deputy commander) to whom the Military Installation Department of Public Health’s chief reports that has responsibility for the Military Installation Department of Public Health; or other external partners, such as off-post partners; as well as other departments, units, or agencies at the MTF or on the installation, for example.</p> <p>In addition to the examples provided within <b>The Standards</b>, the Military Installation Department of Public Health could demonstrate communicating implications to one or more <b>external</b> stakeholders through email messages, Executive Summaries (EXSUMs), Information Papers (IPs), reports or interim progress reports, briefings, minutes of meetings where the implications were presented, or other communications such as websites or social media.</p>
<p><b>Measure 9.2.4 A Foster innovation.</b></p>	<p><b>Required Documentation 1:</b>  In addition to the examples provided in <b>The Standards</b>, the Military Installation Department of Public Health could also describe, for example, conducting a stand-down or brainstorming session focused on innovation topics.</p>

<p><b>Domain 10</b></p> <p><b>Build and maintain a strong organizational infrastructure for public health.</b></p>	
<p><b>STANDARD 10.1</b></p> <p><b>Employ strategic planning skills.</b></p>	
<p><b>Measure 10.1.1 A Conduct a department-wide strategic planning process.</b></p> <p><b>Required Documentation 1: For required element b, sub-element iii, consideration of financial sustainability is <u>not</u> required for Military Installation Departments of Public</b></p>	<p><b>Required Documentation 1:</b>  The planning process may have been facilitated by staff of the Military Installation Department of Public Health or the larger agency (e.g., Medical Treatment Facility (MTF)) in which the department resides, or by an outside consultant. The Military Installation Department of Public Health’s process may have been part of a larger strategic planning process for the organization to which it belongs (e.g., MTF). If such is the case, the Military Installation Department of Public Health must have been actively engaged in the process and must provide evidence that public health was an integral component in the process.</p> <p><b>For required element a:</b>  In addition to participation among various levels of staff, participation by the Military Installation Department of Public Health’s governing entity includes the commander to whom the chief of the Military Installation Department of Public Health reports (Medical Treatment Facility (MTF) commander or another designated commander, for example) unless otherwise specified; or an advisory board, such as the Medical Treatment Facility (MTF) command team.</p> <p><b>For required element b:</b></p>

<p><b>Health. Instead, the only required considerations for this sub-element for Military Installation Department of Public Health's strategic planning process are the capacity for the enhancement of workforce development, communication, and information management or technology.</b></p>	<p>In addition to the examples provided in the guidance, the Military Installation Department of Public Health could also consider the impact of new leadership; new or evolving partnerships; hiring freezes or military recruiting challenges; changes in Department of Defense (DoD) or military service department priorities, processes, or technology; or events such as emerging public health issues, natural disasters, etc.</p> <p>iii. The Military Installation Department of Public Health does <b>not</b> need to include consideration of financial sustainability. Instead, the strategic planning process will focus on consideration of the capacity for enhancing workforce development (including ensuring adequate staffing), communication, <b>and</b> information management or technology.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 10.1.2 A</b> <b>Adopt a department-wide strategic plan.</b></p>	<p><b>Required Documentation 1:</b> If the Military Installation Department of Public Health's strategic plan is part of a broader or larger overarching agency plan (e.g., included within the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), or another agency's strategic plan), the larger/other agency plan must include a section that addresses the Military Installation Department of Public Health and includes the required elements that are specific to the department. Submitted documentation should include only the section(s) of the larger plan that addresses the Military Installation Department of Public Health, not the entire plan. If the strategic plan of the overarching agency (e.g., Medical Treatment Facility (MTF)) does not include the required elements for the Military Installation Department of Public Health, then the department will document that it has conducted an internal strategic planning process and adopted a department-specific strategic plan.</p>
<p><b>Measure 10.1.3 A</b> <b>Monitor implementation of the department-wide strategic plan.</b></p>	<p><b>Required Documentation 1:</b> If monitoring of progress towards all strategic plan objectives is performed by an umbrella agency (e.g., Medical Treatment Facility (MTF)), the Military Installation Department of Public Health's participation or contribution to the review process may be indicated in the examples or described in the Documentation Form. Alternatively, if the Military Installation Department of Public Health's strategic plan is contained within the plan of an umbrella agency (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), MTF, etc.), and progress reports are not available or conducted by that agency, the Military Installation Department of Public Health may develop its own progress reports showing strategic plan implementation, and the progress reports may focus only on the Military Installation Department of Public Health's specific strategic plan objectives.</p> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, communication with the governing entity regarding implementation of the strategic plan could include, for example, the Medical Treatment Facility (MTF) commander. For a description of the governing entity or advisory board (e.g., MTF command team), refer to the introduction of <b><i>The Supplemental Guidance</i></b> (this document).</p>

**STANDARD 10.2**

**Manage financial, information management, and human resources effectively.**

<p><b>Foundational Capability Measure</b></p>	<p><b>Required Documentation 1:</b>          Some Military Installation Departments of Public Health may use policies and procedures that are not specific to their department but are those of the umbrella agency of which the Military Department of Public Health is a part, or are military service department-specific or Department of Defense (DoD)-wide. Policies and procedures may be managed, for example, by the Medical Treatment Facility (MTF) Human Resources (HR), Resource Management (RM), Information Management (IM), or other departments. These policies and procedures could demonstrate compliance with the measure if they apply to the Military Installation Department of Public Health as well as other umbrella agency entities, units, or departments.</p> <p>The policies and procedures used to demonstrate this requirement must pertain to the Military Installation Department of Public Health as a whole. Program-specific policies would <b>not</b> meet the intent of this requirement. The review and revision of Office of Personnel Management (OPM) policies would <b>not</b> meet the intent of this requirement.</p> <p>*Note: Documentation for this requirement may be similar in intent or the same as that used for Medical Treatment Facility (MTF) health care accreditation. If applicable, coordinate with appropriate entities within the Medical Treatment Facility (MTF) to identify whether the health care accreditation documentation may also apply to and/or support this public health accreditation requirement. It should be noted, however, that documentation assessed as acceptable by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p><b>For required element a:</b>          The Military Installation Department of Public Health’s policies or procedures do not need to be created by the department and could be developed by a larger agency or supporting organization (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.). However, the examples provided for this measure should be those <i>used</i> by the Military Installation Department of Public Health and should include a description of the process, frequency, and method used by the Military Installation Department of Public Health to influence reviews and revisions. If there have been no reviews or revisions to policies or procedures developed by an umbrella agency (e.g., MTF), higher-level agency, or supporting organization within the past 5 years, the Military Installation Department of Public Health could demonstrate to the agency that sets the policy that the department has conducted a review of, and provided input on, suggested changes to the policy. Documentation might include, for example, a Memorandum for Record (MFR) signed by the department’s chief codifying the review and record of suggested changes submitted to the agency that sets the policy, for example, as a fax, email, or other record.</p> <p><b>For required element b:</b>          The Military Installation Department of Public Health might consider, for example, how operational policies or procedures are accessible to its staff through a variety of means, such as screenshots of a shared file folder or intranet page, emails to staff with the file location or revised policies or procedures attached, or photos. The Military Installation Department of Public Health could provide examples of how staff are aware of policies or procedures applicable to the installation but maintained by the Office of Personnel Management (OPM), Defense Health Agency (DHA), the Medical Treatment Facility (MTF), or others, if policies are not developed and updated directly by the Military Installation Department of Public Health.</p> <p><b>Required Documentation 2:</b>          The Military Installation Department of Public Health may either adopt its own definitions of equity terms or rely on government-wide, higher headquarters, or umbrella agency (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.) definitions. Adopted definitions of equity terms may be developed by the Army Equity and Inclusion Agency, for example. Military Installation Departments of Public Health might also consider PHAB’s Inclusion, Diversity, Equity, or</p>
<p><b>Measure 10.2.1 A</b>  <b>Manage operational policies including those related to equity.</b></p>	

	<p>Anti-Racism (IDEA) glossary as an additional source of terms and definitions. The Military Installation Department of Public Health could also adopt its own definitions that are relevant to the jurisdiction or based on input from diverse participants to ensure definitions are meaningful to all staff.</p> <p><b>Required Documentation 3:</b> The Military Installation Department of Public Health may use its own department-specific policy or initiative that reflects specific intention focused on inclusion, diversity, equity, or anti-racism or may use that of an umbrella agency of which it is a part (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.), as long as the policy is applicable to the Military Installation Department of Public Health.</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 10.2.2 A</b></p> <p><b>Maintain a human resource function.</b></p> <p><b>Required Documentation 1: For Military Installation Departments of Public Health, human resource policies or procedures documentation requirements apply only to civilian personnel.</b></p>	<p><b>Required Documentation 1:</b> The Military Installation Departments of Public Health may rely upon some or all human resource policies and procedures that are military service-specific, Defense Health Agency (DHA)-specific, or Department of Defense (DoD)-wide. Policies and procedures may be managed by, for example, the Medical Treatment Facility (MTF) Human Resources (HR), Resource Management (RM), Office of Personnel Management (OPM), or other departments. These policies and procedures could demonstrate compliance with the measure if they apply to the Military Installation Department of Public Health as well as other military entities, units, or departments. For example, the MTF, as the Military Installation Department of Public Health’s umbrella organization, may use the <i>Management-Employee Relations Handbook for Army Supervisors and Managers</i> as its policies and procedures for human resource functions. Alternatively, a Defense Health Agency (DHA) procedures manual or similar document may be used by the Military Installation Departments of Public Health. The policies and procedures must pertain to the Military Installation Department of Public Health’s civilian workforce as a whole. Program-specific policies or procedures would <b>not</b> meet the intent of the measure.</p> <p>*Note: Documentation for this requirement may be similar in intent or the same as that used for Medical Treatment Facility (MTF) health care accreditation. If applicable, coordinate with appropriate entities within the MTF to identify whether the health care accreditation documentation may also apply to and/or support this public health accreditation requirement. It should be noted, however, that documentation assessed as acceptable by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p><b>For required elements a and b:</b> For Military Installation Departments of Public Health, veteran’s hiring preference, military spouse preference, and individuals with disabilities preference policies may be submitted in place of personnel and selection policies, and appointment and/or Equal Opportunity Employment policies. The policies and procedures submitted may also be those of the Office of Personnel Management (OPM) or of a regional human resources agency such as the Civilian Human Resources Agency (CHRA) or Civilian Personnel Action Center (CPAC), as used by the Military Installation Department of Public Health or its umbrella agency (e.g., Medical Treatment Facility (MTF), that provides support to the Military Installation Department of Public Health for human resources functions. If the Military Installation Department of Public Health or its umbrella agency has its own Equal Opportunity Employment policy in place, then that policy should be submitted.</p> <p><b>For required element d and e:</b></p>

	<p>The salary structure that applies to Military Department of Public Health civilian personnel may be demonstrated by policies, procedures, or rules available from the Office of Personnel Management (OPM) or other Federal or Department of Defense (DoD) office(s) since this salary structure is set at these levels. If special incentives are available locally for civilian personnel working at the Military Installation Departments of Public Health, these policies should also be provided. Since a large portion of the benefits packages (e.g., health, dental, vision and life insurance; leave; paid holidays; retirement planning; family leave) available to civilian personnel at Military Installation Departments of Public Health apply to all Federal civilian personnel, these Office of Personnel Management (OPM) policies should be provided and will demonstrate this requirement. Other aspects of benefits packages, such as flexible schedules, remote work opportunities, or other policies such as health and wellness offerings, may vary at each Military Installation Department of Public Health or their umbrella agencies (e.g., MTF); these policies should be provided. If the benefits policies of an umbrella or broader organization (e.g., Defense Health Agency (DHA)) apply, and more detailed local policies are not in place, the benefits policies of the umbrella or broader organization should be provided as long as they directly apply to the Military Installation Department of Public Health.</p> <p><b>For required element f:</b> Performance evaluation processes at Military Installation Departments of Public Health or their umbrella agencies (e.g., Medical Treatment Facility (MTF)) may currently use the Department of Defense Performance Management and Appraisal Program (DPMAP). If this is the only process used, then the Military Installation Department of Public Health can provide policy and procedures that specify DPMAP is in use. If the Military Installation Department of Public Health or its umbrella agency uses other alternative or complementary processes, including, but not limited to, Competency Assessment Files (CAF), then policies or procedures showing the alternative is the process in place should also be included.</p>
<p><b>Foundational Capability Measure</b></p> <p><b>Measure 10.2.3 A</b></p> <p><b>Support programs and operations through an information management infrastructure.</b></p> <p><b>Required Documentation 1:</b> <b>For required element b, the Military Installation Department of Public Health has the option of describing how those requests are reviewed or providing an example showing that a submitted request was reviewed. (If providing an</b></p>	<p><b>Required Documentation 1:</b> Military Installation Departments of Public Health use multiple processes for health department information management updates, enhancements, or updates that vary based on the system or need. These processes may include submitting requests to one or more umbrella agencies (e.g., Medical Treatment Facility (MTF) or a broader agency (e.g., Defense Health Agency (DHA)) and may vary by specific information management system. Examples include submitting a request for access to, or expansion of access to, Disease Reporting System internet (DRSi) to the applicable military agency such as DHA Public Health /a Defense Centers for Public Health (DCPH)); or an individual request submitted to the DHA Global Support Center for a general hardware issue (e.g., a malfunctioning computer), which is then prioritized and actioned by the local information management department. Military Installation Departments of Public Health may use the processes or procedures of their umbrella agency or a broader agency and can choose only <b>one</b> process to submit for this requirement, even if it does not cover the health department's full scope of processes for information systems improvements. Documentation examples could be a specific policy, process, or procedure in full format, or web screenshots of a specific process or procedure. The policy, process, or procedure will cover both how staff make requests (required element a) and how requests are reviewed; or an example of a request that has been reviewed (required element b). The process or example for required element b must relate to the process provided for required element a.</p> <p><b>For required element b:</b> The Military Installation Department of Public Health may have limited ability to actually review and prioritize requests for improvements to information management systems. If no review or prioritization process exists for requests within the department, documentation might include any <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• A process used by an umbrella agency (e.g., MTF), higher-level agency, or partner agency to review requests submitted by the Military Installation Department of Public Health (e.g., a standard operating procedure (SOP), or flow chart);</li> </ul>

<p><b>example of a submitted request, the Documentation Form may be used to describe the review process if not evident in the documentation.)</b></p>	<ul style="list-style-type: none"> <li>• A process used by the Military Installation Department of Public Health to review requests prior to submission to the umbrella agency (e.g., MTF), higher-level agency, or partner agency. Examples include a department leader's review and approval of a request prior to a department staff member submitting it to another agency; <b>or</b></li> <li>• An example of a request that was submitted by the department and reviewed by the umbrella agency (e.g., MTF), higher-level agency, or partner agency. These requests might include, for example, updating the Military Installation Department of Public Health's portion of the website if updating public health information or improving outreach through the website cannot be actioned internally by the department and requires submission of an update request to the umbrella agency (e.g., Medical Treatment Facility (MTF)) or Defense Health Agency (DHA). Another potential example is the Military Installation Department of Public Health providing a request, which was subsequently reviewed, to replace outdated technology or hardware/software applications. Documentation may also include the request response the department received from the other agency. If the Military Installation Department of Public Health chooses to describe how the requests are reviewed once submitted, the department should provide this description in the Documentation Form as it may not be evident in the process description used in Required Documentation 1.</li> </ul>
<p><b>Foundational Capability Measure</b> <b>Measure 10.2.4 A</b> <b>Protect information and data systems through security and confidentiality policies.</b></p>	<p><b>Required Documentation 1:</b> The purpose of this measure is to assess how the Military Installation Department of Public Health protects the security of its data systems and confidential information from risks and potential threats. Military Installation Departments of Public Health may rely on government-wide, higher headquarters, or umbrella agency policies (e.g., those of the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.) and may use those policies as evidence, if applicable to the department. Such policies may provide general provisions to protect the security of data systems and confidential data across multiple information systems or repositories, or separate policies that address specific systems used by the Military Installation Department of Public Health. For example, separate policies may address specific requirements for systems used by the Military Installation Department of Public Health, such as electronic information and data submission to MHS Genesis, the Medical Protection System (MEDPROS), Defense Occupational and Environmental Health Readiness System (DOEHRS), or Disease Reporting System internet (DRSi), as long as each addresses required elements a–c.</p> <p><b>For required element a:</b> The policy or set of policies describing requirements for password complexity and lifespan may apply across the Military Installation Department of Public Health's information management assets, or separate policies may cover separate systems. As an alternative, the policies or set of policies could also address alternative methods used beyond password access, such as use of a common access card (CAC), personal identification number (PIN), or other methods used for the purposes of ensuring access among appropriate personnel. It is <b>not</b> necessary to provide separate policies of system password requirements and lifespan for each separate system used by the Military Installation Department of Public Health.</p> <p><b>Required Documentation 2:</b> <b>Required element a:</b> In addition to the guidance provided in <i>The Standards</i>, training on password best practices may also address alternative methods used to keep information and data systems secure, such as using common access cards (CACs), personal identification numbers (PINs), or other similar methods. It is not necessary that the training content address separate processes for each system used by the Military Installation Department of Public Health; rather, the training will address best practices for the use of protecting information management assets (e.g., PIN complexity or length, CAC card issuance or use, etc.).</p> <p><b>Documentation Examples</b></p>

	<p>In addition to the guidance provided in <i>The Standards</i>, documentation could include a screenshot of the Joint Knowledge Online (JKO) training site or the Army Learning Management System (ALMS) to show that certificates are issued when each employee completes the training, or a report pulled from one or more of these systems to show who has and has not completed all relevant trainings.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 10.2.6 A</b> <b>Oversee grants and contracts.</b></p> <p><b><u>Required Documentation 1:</u></b> <b>For Military Installation Departments of Public Health, the examples must be program reports submitted to higher-level agencies.</b></p> <p><b><u>Required Documentation 2:</u></b> <b>This requirement does not apply to Military Installation Departments of Public Health. No documentation is required to demonstrate all formal communications from state or federal funders that indicate the health department is a “high-risk grantee.”</b></p>	<p><b><u>Required Documentation 1:</u></b> Since Military Installation Departments of Public Health typically do not receive grants or operate under contractual agreements to provide their services, the examples may instead reflect how the department’s program (status) reports demonstrate that the department is making progress in providing public health services and programs with the resources provided to it. These program (status) reports may be those that the department submits to a higher-level agency (e.g., Defense Health Agency (DHA) market/network, DHA Public Health, DHA Headquarters, or military service medical department (e.g., U.S. Army Medical Command (MEDCOM)) that oversees the department and/or its activities. Examples will reflect program (status) reports from two different program areas. These reports could be progress reports of services performed, activities completed, or clients served, such as, for example, Defense Occupational and Environmental Health Readiness System (DOEHRS) reports of environmental health inspections or industrial hygiene worksite visits/surveys; Armed Forces Wellness Center (AFWC) Health and Wellness Tracker reports of group classes provided; or Public Health Nursing or other periodic program status reports (PSRs), etc., that describe the work completed by the health department.</p> <p><b><u>Required Documentation 2:</u></b> This requirement does <b>not</b> apply to Military Installation Departments of Public Health.</p> <p><b><u>Required Documentation 4:</u></b> In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health could provide an example of an improvement made to managing written agreements (e.g., Memorandums of Understanding (MOUs) or Memorandums of Agreement (MOAs)), by for example, demonstrated improved processes for monitoring and tracking the status, timeliness or quality of deliverables; or other aspects of contract management, such as streamlining processes (e.g., spend-down processes or reporting); or applying a diversity or equity lens to the acquisition process or requirements. The example may also be one that details the department’s work in conjunction with an umbrella agency (e.g., Medical Treatment Facility (MTF)) or another department of the umbrella organization, for example, the MTF Resource Management or Contracts Department, as long as the improvement relates to public health services or operations to support public health (e.g., to support workforce, facilities, data systems, etc., that are used by public health staff).</p>
<p><b>Foundational Capability Measure</b> <b>Measure 10.2.7 A</b> <b>Manage financial systems.</b></p>	<p><b><u>Require Documentation 1:</u></b> The Military Installation Department of Public Health’s quarterly (or monthly) financial reports could be a part of a larger set of reports, such as that of the Medical Treatment Facility (MTF) or the Defense Health Agency (DHA) market/network, as long as the reports contain both the revenue <b>and</b> expenses of the Military Installation Department of Public Health. The financial reports must also be reflective of the entire department, rather than one department program or section, which would <b>not</b> meet the intent of the requirement.</p>

	<p>Note: Full versions of the financial reports <b>CANNOT</b> be uploaded electronically in a non-governmental information technology system but may be shown in person during the site visit.</p> <p><b>Required Documentation 2:</b> The Military Installation Department of Public Health’s audit could be a part of a larger audit of the Medical Treatment Facility (MTF) or the Defense Health Agency (DHA) market/network of which the department is a part. The audits must be reflective of a full financial audit of the Military Installation Department of Public Health or the broader or umbrella agency and not an audit of only a single Department of Public Health program or section. The audit can be conducted by any entity external to the entity being audited (e.g., the DHA may audit an individual MTF).</p> <p><b>Required Documentation 3:</b> The example provided can be steps or corrective actions identified or taken directly by the Military Installation Department of Public Health or an umbrella agency of which it is a part (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.).</p>
<p><b>Measure 10.2.8 A</b> <b>Evaluate finances and seek needed resources to support ongoing and emergent needs.</b></p>	<p><b>Required Documentation 1:</b> For Military Installation Departments of Public Health, the analysis could be performed by the department or others, for example, at the umbrella agency level (e.g., Military Treatment Facility (MTF)) or at a higher level, such as a DHA market/network or DHA Headquarters, as long as the analysis is specific to public health infrastructure or public health services in the jurisdiction served by the installation.</p> <p><b>Required Documentation 2:</b> In addition to the examples provided in <i>The Standards</i>, Military Installation Departments of Public Health may demonstrate this requirement through unfunded requests (UFRs) made. Requests for budget increases or revisions or UFRs may be demonstrated through briefing slides, Executive Summaries (EXSUMs), Information Papers (IPs), White Papers, or email messages. The examples of requests provided do not need to have been successful.</p> <p>Engagement with the Military Installation Department of Public Health’s governing entity could include requesting funding from that entity; communicating to the governing entity about the need for additional financial resources or efforts to increase efficiencies; or having the governing entity, in conjunction with the health department, communicate with others such as a higher-level command (e.g., U.S. Army Medical Command (MEDCOM) or an Army Medical Readiness Command (MRC) (previously known as a Regional Health Command (RHC)) or agency (e.g., Defense Health Agency (DHA) or DHA market/network) about the need for additional financial resources. Military Installation Departments of Public Health governing entity engagement in this case can be with any member of that governing entity (e.g., Medical Treatment Facility (MTF) command team) and not the highest-ranking person within that entity.</p> <p>In addition to the documentation examples specified in <i>The Standards</i>, Military Installation Departments of Public Health may use email requests, briefing slides, memorandums, or Memorandums of Understanding (MOUs).</p> <p><b>Required Documentation 3:</b> In addition to the examples provided in <i>The Standards</i>, Military Installation Departments of Public Health might reflect how the department rapidly deployed a new or revised program or strategy, or additional resources, for example, by expediting written agreements with other entities based on unexpected or unplanned events, or how the department demonstrated flexibility to sustain critical operations. Documentation could include an email or memorandum, other written correspondence, or agreements executed</p>



	with others to demonstrate flexible financial management, which may be developed by or in collaboration with an umbrella agency (e.g., the Medical Treatment Facility (MTF) or another department of the MTF).
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<p><b>STANDARD 10.3</b></p> <p><b>Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision-making, and governance.</b></p> <p>For Military Installation Departments of Public Health, the Medical Treatment Facility (MTF) commander is considered to be the governing entity, defined as the body with legal authority over the public health functions of a jurisdiction (<i>PHAB Acronyms &amp; Glossary of Terms, Version 2022</i>). PHAB defines “advisory boards” as one or more entities that serve in an advisory role to provide guidance on decision making about the overall health department operations or public health in the jurisdiction. For Military Installation Departments of Public Health, advisory boards may refer to the Medical Treatment Facility (MTF) command team, for example.</p>	
<p><b>Measure 10.3.1 A</b> <b>Deliberate and resolve ethical issues.</b></p>	<p><b>Required Documentation 1:</b> The Military Installation Department of Public Health may maintain its own process to deliberate upon and resolve ethical issues. Alternatively, the Military Installation Department of Public Health might rely upon such a process developed or maintained by a broader or umbrella agency, such as the Medical Treatment Facility (MTF), under the direction of the MTF commander or command team, if the process includes required elements a–d. If the process of a broader or another agency is used and only addresses some of the required elements (e.g., required elements a–c, but not d), the Military Installation Department of Public Health could also develop a supplemental or companion document describing the process that would be used for the remaining required element (e.g., addressing required element d). The process may be described in an ethics training, a policy or procedure, or a description of the functions of an Ethics Committee, for example, or another document describing the process to deliberate upon and resolve ethical issues in compliance with appropriate command and control channels and military procedures.</p> <p><b>Required Documentation 2:</b> The Military Installation Department of Public Health will provide evidence of application of the process for ethical issues (from Required Documentation 1). If the process described in Required Documentation 1 is that of a broader or umbrella agency, the Military Installation Department of Public Health will show how that process was applied to the resolution or prevention of the occurrence of an ethical issue within the context of the Military Installation Department of Public Health, such as in the deliberation of a public health, management, or other issue of the Military Installation Department of Public Health. Examples of ethical issues include addressing child vaccination exemptions in Child and Youth Services (CYS), distribution of flu vaccine in a shortage situation, an employee’s use of social media, or an employee’s acceptance of gifts.</p>
<p><b>Measure 10.3.2 A</b> <b>Orient the governing entity and advisory board.</b></p>	<p><b>Required Documentation 1:</b> For Military Installation Departments of Public Health, the Medical Treatment Facility (MTF) command team; installation coalitions or collaborative groups, such as the Commander’s Ready and Resilient Council (CR2C) or CR2C Working Groups; may also serve in advisory board capacities. The Military Installation Department of Public Health will show examples orienting each of these entities. The orientation process and content may differ based on the governing entity or advisory board role and associated responsibilities. If others provide the orientation, the Military Installation Department of Public Health may demonstrate how it supplements or works with the other entity that provides the orientation to ensure the materials address required elements a–c.</p>

	<p><b>For required element a:</b> The Military Installation Department of Public Health must document that it shared with the Medical Treatment Facility (MTF) commander the selected and relevant operational definitions and/or statements of the department's role and responsibilities related to public health. The Military Installation Department of Public Health will select its documentation based on, and appropriate to, the relevant command and service-specific regulations. Examples of documentation include command or installation health reports, meeting minutes, Memorandums for Record (MFRs), emails, briefing documents, or other correspondence.</p> <p><b>For required element b:</b> The public health responsibilities of the governing entity or advisory group for Military Installation Departments of Public Health may be specified in service-specific regulations (e.g., Army Regulation (AR) 40–5, <i>Army Public Health Program</i>; AR 600–63, <i>Army Health Promotion</i>), or documents such as policies or procedures within Department of Defense instructions (DoDIs), or the Defense Health Agency (DHA) or DHA markets/networks.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 10.3.3 A</b> <b>Communicate with governance routinely and on an as-needed basis.</b></p>	<p><b>Required Documentation 1:</b> Methods of regular communication with its governing entity (e.g., Medical Treatment Facility (MTF) commander or their designee), could include, for example, regularly scheduled meetings such as Command and Staff meetings; scheduled correspondence; such as weekly situation reports (SITREPs); Executive Summaries (EXSUMs); weekly update reports (WURs); or other scheduled written materials or briefings. In addition to the examples in <b><i>The Standards</i></b>, the method(s) and frequency of regular communications with a Military Installation Department of Public Health's governing entity could be described in a memo, policy, standard operating procedure (SOP), or email message calling for updates. The Documentation Form may be used to indicate additional or alternate communication methods and the frequency of regular communication, as well as whether the Military Installation Department of Public Health has multiple governing entities or mandated advisory boards or only one.</p> <p><b>Required Documentation 2:</b> For Military Installation Departments of Public Health, additional documentation examples beyond those specified in <b><i>The Standards</i></b> may include Executive Summaries (EXSUMs), situation reports (SITREPs), briefings, or email messages where the emerging issue is noted or discussed between the Military Installation Department of Public Health and the governing entity.</p> <p><b>Required Documentation 3:</b> In addition to the documentation examples specified in <b><i>The Standards</i></b>, Military Installation Departments of Public Health could use a weekly report or newsletter shared with all department staff.</p>
<p><b>Foundational Capability Measure</b> <b>Measure 10.3.4 A</b> <b>Access and use legal services in planning, implementing, and enforcing public health initiatives.</b></p>	<p><b>Required Documentation 1:</b> Legal review within the originating Department of Defense (DoD) organization is inherent in the development and approval process of any policy or regulation at any level. Every Military Installation Department of Public Health has natural access to legal counsel either within its umbrella organization (e.g., Medical Treatment Facility (MTF)), a broader organization (e.g., Defense Health Agency (DHA)), or on the installation (i.e., Judge Advocate General's Office).</p>