



Standards & Measures – Version 2022
Supplemental Guidance for Military
Installation Departments of Public Health
Pathways Recognition

Adopted January 2024



“This publication was developed under the direction of the Defense Centers for Public Health–Aberdeen (DCPH-A), Defense Health Agency Public Health (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 Pathways Recognition, Version 2022* to reflect military terminology, operations, and scope of practice within the installation department 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 Pathways Recognition, Version 2022, referred to as “The Standards”**, serves as the official standards, measures, required documentation, and guidance for the PHAB Pathways Recognition Program. 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 Pathways Recognition, 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 document. 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) in September 2022 to develop supplemental guidance tailored to support Military Installation Departments of Public Health. 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, and the MTFs in which they are embedded, having been 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 Pathways Recognition 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 Review 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 Pathways Recognition and 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 Pathways Recognition 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 Pathways Recognition 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 the **Policy for PHAB Pathways Recognition Program**.
- 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 may differ, 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 there is 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, 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.

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 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.

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 with consideration of 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, 10.2.2 A, Required Documentation 1, specifies human resource policies or procedures apply only to civilian personnel within a Military Installation Department of Public Health. As reflected below, the difference in requirements is reflected in **bold red font** in the far-left column.

<p>Measure 10.2.2 A Maintain a human resource function.</p> <p><u>Required Documentation 1:</u> For Military Installation Departments of Public Health human resource policies or procedures, documentation requirements apply only to civilian personnel.</p>	<p>In this example for Measure 10.2.2 A, the difference in requirements is reflected in bold red font in the far-left column.</p>
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Nomenclature

The Pathways Recognition 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

For the purposes of the PHAB Pathways Recognition Program, 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 Pathways Recognition, 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 (DCPH), such as 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 Pathways Recognition 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 Pathways Recognition 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 files may contain confidential information that **CANNOT** be uploaded to PHAB’s non-governmental electronic information technology system (e-PHAB). Instead, the Military Installation Department of Public Health is encouraged to redact any confidential information prior to uploading to e-PHAB. If redaction would result in the documentation not demonstrating measure requirements, the department will use the Documentation Form to indicate that the document contains confidential information and **CANNOT** be uploaded. PHAB will then work with the health department to hold a virtual documentation review session during which the health department can screenshare the documents for the Review Team to complete its 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 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 Pathways Recognition 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 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 department Pathways Recognition 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

The Supplemental Guidance is accompanied by a sourced, military-specific (Army-centric) [Acronyms Glossary](#), which was 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.

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.

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 **not** 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; *Health of the Force* 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.

For required element d:

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.

For required element e:

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.

For required element f:

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.

For required element g:

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.

STANDARD 1.2

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

Measure 1.2.1 A Collect non-surveillance population health data.

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.

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.

If the Military Installation Department of Public Health's role in data collection is not evident, it could be clarified in the Documentation Form.

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.

While surveillance data, program evaluation, and customer satisfaction do **not** 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.

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.

Required Documentation 1:

For required element a:

In addition to the examples provided within *The Standards* or above guidance, a Military Installation Department of Public Health could also consider primary quantitative 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>For required element 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>Required Documentation 2: 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>Measure 1.2.2 T/L Participate in data sharing with other entities.</p>	<p>Required Documentation 1: 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>
<p>STANDARD 1.3 Analyze public health data, share findings, and use results to improve population health.</p>	
<p>Measure 1.3.1 A Analyze data and draw public health conclusions.</p>	<p>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.</p> <p>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, <i>Health of the Force</i> reports or <i>Health of the Force</i> Online, or other data.</p> <p>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</p>

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.

For required element c:

In addition to the examples provided within *The Standards*, 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.

Required Documentation 2:

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>For required element 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>
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Domain 2
Investigate, diagnose, and address health problems and hazards affecting the population.

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

<p>Foundational Capability Measure Measure 2.1.1 A Maintain surveillance protocols.</p>	<p>Required Documentation 1: In addition to the surveillance system examples provided within <i>The Standards</i>, 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.</p> <p>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 Centers for Public Health/DHA Public Health, 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.</p> <p>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,</p>
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	<p>regional or state agreements, regulation, or other arrangements. The Military Installation Department of Public Health defines from whom reports are received.</p> <p>For required element b: In addition to the data quality control measure examples provided within <i>The Standards</i>, 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> <p>For required element c: 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>For required element d: 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>For required element g: 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>Foundational Capability Measure Measure 2.1.3 A Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health</p>	<p>Required Documentation 1: For required element a: 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>For required element b:</p>

<p>problems and environmental public health hazards.</p> <p>Required Documentation 1. Additional required element c. For Military Installation Departments of Public Health, the policy(ies) or procedure(s) must also address occupational health hazards.</p>	<p>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>For required element c: 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>Required Documentation 2: For <u>each</u> 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>Required Documentation 3: 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>
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STANDARD 2.2
Prepare for and respond to emergencies.

<p>Measure 2.2.1 A Maintain a public health emergency operations plan (EOP).</p> <p>Measure 2.2.1 A Maintain a public health emergency operations plan (EOP).</p> <p>Required Documentation 1. For required element b, indicate the portion of the EOP that addresses the roles and responsibilities of</p>	<p>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.</p> <p>Required element b: The incident command system, as stated in <i>The Standards</i>, 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 <i>within</i> 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.</p> <p>Required element c: In addition to populations outlined within <i>The Standards</i>, 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</p>
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<p>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).</p>	<p>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.</p> <p>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.</p> <p>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 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>Required element h: 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>Measure 2.2.5 A Maintain and implement a risk communication plan for communicating with the public during a public health crisis or emergency.</p>	<p>Required Documentation 1: 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) market/network, 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>by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.</p> <p>For required element a: 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) Public Health (DHA Public Health), DHA market/network, 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>For required element 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>For required element c: 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>For required element g: 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>For required element h: 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>For required element i: 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>Measure 2.2.6 A Maintain and implement a process for urgent 24/7 communications with response partners.</p>	<p>Required Documentation 1: 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</p>

	<p>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>For required element a: 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>For required element 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><u>Required Documentation 2:</u> 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>Measure 2.2.7 A Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.</p>	<p><u>Required Documentation 1:</u> 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><u>Required Documentation 2:</u> 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>For required element c: 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>For required elements d and e: 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.

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>For required element e: 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>Required Documentation 2: 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>Required Documentation 3: 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>STANDARD 3.2</p> <p>Use health communication strategies to support prevention, health, and well-being.</p>	
<p>Measure 3.2.2 A Implement health communication strategies to encourage actions to promote health.</p>	<p>Required Documentation 1 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"> • 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),

- 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
- 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.

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/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 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

	<p>Treatment Facility (MTF) Commander; Defense Health Agency (DHA) headquarters; a Defense Center 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.</p>
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Domain 4
Strengthen, support, and mobilize communities and partnerships to improve health.

STANDARD 4.1
Engage with the public health system and the community in promoting health through collaborative processes.

<p>Measure 4.1.2 A Participate actively in community health coalition(s).</p>	<p>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.</p> <p>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.</p> <p>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</p>
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	<p>(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.</p> <p>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.</p> <p>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 <i>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)</i> 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>
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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>Measure 5.1.2 A Examine and contribute to improving policies and laws.</p>	<p>Required Documentation 1: 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 not 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</p>
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	<p>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>For required element a: 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>For required element c: 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>
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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.

<p>Measure 5.2.2 A Adopt a community health improvement plan.</p>	<p>Required Documentation 1: For required element c:</p> <ol style="list-style-type: none"> 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. 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. <p>For required element d: 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</p>
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	<p>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>For required element e: 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>Measure 5.2.4 A Address factors that contribute to specific populations' higher health risks and poorer health outcomes.</p>	<p><u>Required Documentation 1:</u> 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><u>Required Documentation 2</u> 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 6.1.4 A
Conduct enforcement actions.

Required Documentation 1-4:
For Military Installation Departments of Public Health, this measure is not applicable, and no documentation is needed for these requirements.

Required Documentation 1-4:

For Military Installation Departments of Public Health, this measure is not applicable, and **no** documentation is needed for these requirements.

However, the Military Installation Department of Public Health is encouraged to review and reflect on the importance of public health regulations and laws to promote and protect the health of the population, including how public health-related regulations, whether originating from the Military Installation Department of Public Health or another entity are operationalized, considering cultural, linguistic, or other communication considerations to improve compliance.

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 7.2

Connect the population to services that support the whole person.

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

Required Documentation 1:

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—

- 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).
- 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.
- 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).
- Integration of behavioral or social service questions into screenings.

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.

Measure 8.1.2 A
Recruit a qualified and diverse health department workforce.

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).

In addition to the examples provided within *The Standards*, 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.

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

	<p>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>
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STANDARD 8.2
Build a competent public health workforce and leadership that practices cultural humility.

<p>Measure 8.2.1 A Develop a workforce development plan that assesses workforce capacity and includes strategies for improvement.</p>	<p>Required Documentation 1:</p> <p>For required element a: 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.</p> <p>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.</p> <p>For required element c: In addition to the equity assessments provided in <i>The Standards</i>, 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.</p> <p>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.</p> <p>For required element e:</p>
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	<p>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 <u>or</u> develop strategies that address both.</p> <p>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 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 <u>or</u> 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>Measure 8.2.2 A Provide professional and career development opportunities for all staff.</p>	<p>For Required Documentation 1: 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)/Defense Centers 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 not 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>For Required Documentation 2:</p>

	<p>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 training does not need to be public health-focused. It does need to be focused on leadership or management skills and cannot be focused solely on military strategy.</p>
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<p>Domain 9 Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.</p>	
<p>STANDARD 9.1 Build and foster a culture of quality.</p> <p>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>	
<p>Measure 9.1.1 A Establish a performance management system.</p>	<p>Required Documentation 1: 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>For required element a:</p>

	<p>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>
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<p>STANDARD 9.2 Use and contribute to developing research, evidence, practice-based insights, and other forms of information for decision making.</p>	
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<p>Measure 9.2.1 A Identify and use applicable research and practice-based information for program development and implementation.</p>	<p>Required Documentation 1: For required element a: In addition to the examples provided within <i>The Standards</i>, 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>For required element 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 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 <i>The Standards</i>, 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 not 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>
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	<p>For required element c: 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>
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Domain 10
Build and maintain a strong organizational infrastructure for public health.

STANDARD 10.1
Employ strategic planning skills.

<p>Measure 10.1.2 A Adopt a department-wide strategic plan.</p>	<p>Required Documentation 1: 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>
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STANDARD 10.2
Manage financial, information management, and human resources effectively.

<p>Measure 10.2.1 A Manage operational policies including those related to equity.</p>	<p>Required Documentation 1: 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 not meet the intent of this requirement. The review and revision of Office of Personnel Management (OPM) policies would not 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>
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	<p>For required element a: 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>For required element 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><u>Required Documentation 2:</u> 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 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><u>Required Documentation 3:</u> 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>Measure 10.2.2 A Maintain a human resource function.</p> <p>Required Documentation 1: For Military Installation Departments of Public Health, human</p>	<p><u>Required Documentation 1:</u> 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</p>

resource policies or procedures documentation requirements apply only to civilian personnel.

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

*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.

For required elements a and 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.

For required element d and e:

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.

For required element f:

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>Measure 10.2.3 A Support programs and operations through an information management infrastructure.</p> <p>Required Documentation 1: 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 example of a submitted request, the Documentation Form may be used to describe the review process if not evident in the documentation.)</p>	<p>Required Documentation 1: 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 one 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>For required element 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 one of the following:</p> <ul style="list-style-type: none"> • 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); • 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; or <p>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.</p>
<p>Measure 10.2.4 A Protect information and data systems through security and confidentiality policies.</p>	<p>Required Documentation 1: 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</p>

	<p>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>For required element a: 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 not 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>Required Documentation 2: Required element a: 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>Documentation Examples 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>Measure 10.2.6 A Oversee grants and contracts.</p> <p>Required Documentation 1: For Military Installation Departments of Public Health, the examples must be program reports submitted to higher-level agencies.</p> <p>Required Documentation 2: This requirement does not apply to Military Installation Departments of Public</p>	<p>Required Documentation 1: 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>Required Documentation 2: This requirement does not apply to Military Installation Departments of Public Health.</p> <p>Required Documentation 4: 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</p>

<p>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.”</p>	<p>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>Measure 10.2.7 A Manage financial systems.</p>	<p><u>Require Documentation 1:</u> 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 and 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 not meet the intent of the requirement.</p> <p>Note: Full versions of the financial reports CANNOT be uploaded electronically in a non-governmental information technology system (e.g., e-PHAB) but may be shown in person during the site visit.</p> <p><u>Required Documentation 2:</u> 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><u>Required Documentation 3:</u> 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>

STANDARD 10.3

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

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 (*PHAB Acronyms & Glossary of Terms, Version 2022*). 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>Measure 10.3.3 A Communicate with governance routinely and on an as-needed basis.</p>	<p>Required Documentation 1: 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 <i>The Standards</i>, 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>Required Documentation 2: For Military Installation Departments of Public Health, additional documentation examples beyond those specified in <i>The Standards</i> 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>Required Documentation 3: In addition to the documentation examples specified in <i>The Standards</i>, Military Installation Departments of Public Health could use a weekly report or newsletter shared with all department staff.</p>
<p>Measure 10.3.4 A Access and use legal services in planning, implementing, and enforcing public health initiatives.</p>	<p>Required Documentation 1: 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>