

Standards & Measures for Reaccreditation Version 2022

Supplemental Guidance for Military Installation
Departments of Public Health



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

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Introduction

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

This **Supplemental Guidance for Military Installation Department of Public Health Reaccreditation**, referred to as “**The Supplemental Guidance**” has been customized for Military Installation Departments of Public Health that have responsibility for public health services at the installation level according to Army Regulation (AR) 40–5, revision dated May 12, 2020 and 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 DHA (DHA) Medical Treatment Facilities (MTFs) on U.S. Navy-, U.S. Marine Corps, U.S. Air Force-, or U.S. Space Force-led installations unless directed by DHA policy or authority. No such authority or policy is in place at the time of this document’s publication, and **The Supplemental Guidance** provided here does not take into account details of installation public health delivery at these services’ installations. Following the release of **The Standards** in February 2022, the Public Health Accreditation Board (PHAB) engaged with the Defense Centers of Public Health–Aberdeen (DCPH-A) to develop supplemental guidance tailored to support Military Installation Departments of Public Health starting in September 2022. Together, PHAB and the DCPH-A/DHA-PH reviewed **The Standards** to further develop clarifying guidance and examples reflective of public health programs, services, functions, and operations, as well as examples from within a Military Installation Department of Public Health context. In addition, the guidance within **The Supplemental Guidance** was informed by learnings from the previous experiences of accredited military installation departments of public health or those in the process of achieving initial accreditation. It is important to note that as of September 30, 2022, all installation departments of public health and the MTFs in which they are embedded, moved under the authority, direction, and control of the Defense Health Agency (DHA) such that no installation department of public health currently belongs to a military medical 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 reaccreditation to aid in their selection of appropriate documentation demonstrating evidence of the Military Installation Department of Public Health’s conformity with requirements. The guidance is designed to support accreditation coordinators and teams, as well as those providing consultation or technical assistance to Military Installation Departments of Public Health. It also guides PHAB’s site visit teams in their review of documentation submitted by applicants to determine whether conformity with a measure has been demonstrated.

Unless otherwise stated, all references to Military Installation Departments of Public Health in this document refer to the entity that is responsible for local, installation public health services. Although most of these entities will be using the Installation Department of Public Health nomenclature, the actual name may vary for some locations due to local considerations and scope of services (e.g., multiple installations may be included in the department name, or the installation may be a joint base with the department named accordingly). Activities related to military field public health services in an operational (deployed) environment are **excluded** for the purposes of public health department accreditation. Further, the activities of Veterinary Services, which may be part of the Defense Public Health Enterprise, are not reviewed as part of PHAB's accreditation review, although an installation veterinary services clinic may be included as a partner within a Military Installation Departments of Public Health's examples or documents.

Users of ***This 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 reaccreditation and the selection of documents.

Overarching Principles

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

- There is **no change** in the accreditation requirements set forth in ***The Standards, unless explicitly stated***. Any differences in requirements specific to Military Installation Departments of Public Health are indicated in the far-left column in **bold red font**.
- There is **no change** in the PHAB accreditation review process, as set forth in ***PHAB's Policy for National Public Health Department Reaccreditation***.
- PHAB is **not** prescriptive about the use of specific terminology which varies by jurisdiction. While the Standards & Measures may use the terms, "strategies," "risk communication," or "inequities," the specific terms used by the jurisdiction might be different. For example, "strategies" versus "activities," "risk communication" versus "emergency communications," or "inequities" versus "root causes of disparities." Instead, PHAB's review focuses on meeting the intent of requirements. The Documentation Form may be used in these instances to clarify the relationship if in doubt about the specific terminology used.
- In many cases, the documentation guidance in ***The Standards*** remains the same. The documentation guidance that is being provided should be used to *supplement* (rather than to "supplant" or replace) requirements and should be used as clarification of PHAB's expectations in the context of military installation public health practice. *Only* documentation guidance that is unique to Military Installation Departments of Public Health is provided in this document.
- If the user of this document experiences difficulty in understanding what the measure is requiring, Military Installation Departments of Public Health are encouraged to seek technical assistance and guidance by:
 - Consulting the Defense Health Agency's Public Health Accreditation Program Management Team, as a resource providing support on a wide variety of topics to help departments conform to a measure, including, but not limited to, strategic planning, community health assessment and improvement planning, partnerships, public health policy, surveillance, epidemiology, and others.
 - Contacting PHAB's Accreditation Specialists for specific guidance regarding measure or requirement interpretation or questions about the accreditation process, or about technical aspects, such as acceptable documentation (e.g., scope of authority) or file formats.
 - 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 (“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 states that in a military context, partners might include: “community coalitions or collaboratives (e.g., Commander’s Ready and Resilient Councils (CR2Cs or CR2C Facilitator)), installation/garrison assets such as Morale, Welfare, and Recreation (MWR); Army Community Service (ACS); Family Advocacy Program (FAP); Army Substance Abuse Program (ASAP); Directorate of Emergency Services (DES); Child and Youth Services (CYS); safety; mission/tactical assets such as brigades, battalions, companies, public affairs office, headquarters; or medical assets such as nursing, behavioral health, or clinical operations.”

In some instances, no additional guidance is provided within *The Supplemental Guidance*, beyond the guidance already outlined in *The Standards*. If there is no supplemental guidance, the Military Installation Department of Public Health must follow the guidance provided within *The Standards*, as applicable to all health departments. For example, the guidance related to the implementation of a community health improvement plan (CHIP) strategy or activity in Measure 5.2.2 A, Required Documentation 1 is the same as provided in *The Standards* (no supplemental guidance is provided for Military Installation Departments of Public Health), and this requirement has been omitted from *The Supplemental Guidance*.

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

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

The public health accreditation standards, measures, and guidance for documentation apply to all Military Installation Departments of Public Health at Army locations named in MEDCOM OPORD 20-09, published 4 NOV 2019, which vary in size, organizational structure, scope of authority, resources, population

served, governance, and geographic region. “Military Installation Departments of Public Health”, as the term used throughout, refers to the departments located at the installation (“installation-level”).

Population Served

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

Governance and Advisory Board(s)

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

Authorship and Evidence of Authenticity

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

For Reaccreditation, Narrative Descriptions and Narratives of Examples will also include evidence of authenticity by describing the health department’s role in the activity as well as how other entities were engaged, as appropriate. For documentation developed or adopted by the health department, evidence of the Military Installation Department of Public Health’s name, logo, signature, email address, or other evidence that links the document to the health department must be included on the document.

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 Reaccreditation, 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-PH 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 accreditation review. The department must provide evidence of meeting the measure, even if such documentation is produced by another agency, component, unit, or a partner organization. It is advisable for the department to include an explanation using the required Documentation Forms to describe use of documentation developed by others.

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

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

Documentation Not Approved for Electronic Submission

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

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

- **Documents containing personally identifiable information (PII) or protected health information (PHI).** PII or PHI must be redacted from all accreditation documentation.
- **Any document containing financial or personnel system data.**
 - This includes audits, budgets, Program Objective Memorandum (POM) submissions, work plans, statements of operations, requirements planning tools and/or any data or reports from financial, timekeeping, or equipment systems including, but not limited to, Defense Medical Human Resource System internet (DMHRSi), Automated Time Attendance and Production System (ATAAPS), General Fund Enterprise Business System (GFEBS), Medical Expense and Performance Reporting System (MEPRS), or Defense Medical Logistics Standard Support (DMLSS).
- **Controlled Unclassified Information (CUI) documents and other potential sensitive documents** such as, but not limited to, Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), contracts, organizational wiring diagrams containing the names of individuals, and budgetary or financial documents.
 - If only position titles (rather than individual names) are listed, then the 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, 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 the installation's Medical Treatment Facility (MTF). While some of these services may also pertain to the MTF's health care 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 health care accreditation and public health accreditation are similar. To help

applicant Military Installation Departments of Public Health to identify where documentation requirements may be the same or similar to health care 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 accreditation requirement. It should be noted, however, that documentation assessed as acceptable by another accrediting body against its standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.”

Acronyms & Glossary of Terms

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

Domain 1

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

STANDARD 1.1

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

Foundational Capability Measure

Measure 1.1.1 A Develop a community health assessment.

Required Documentation 1

For required element a:

The development of a community health assessment includes the participation of partners representing various sectors of the community, which could include those from the installation and/or local communities neighboring the installation, for example, education, social services, health, transportation, or law enforcement. Partners could also include those represented on community coalitions or collaboratives (e.g., 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

	<p>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, Military 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 in communities surrounding the installation military and community not-for-profit organizations. In addition to secondary data sources listed, Military Installation Departments of Public Health might also consider, for example, the Global Assessment Tool (GAT) or Azimuth Check (formerly known as the Periodic Health Assessment) data; <i>Health of the Force</i>; regular epidemiological reports; the Health Care Survey of DoD Beneficiaries, Behavioral Risk Factor Surveillance Survey (BRFSS) or Youth Risk Behavior Surveillance (YRBSS); County Health Rankings; or Defense Centers for Public Health (DCPH) reports.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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., CR2Cs), Army Community Service (ACS), Armed Forces Wellness Centers (AWCs; formerly known as Army Wellness Centers), or other assets and resources.</p>
<p>Measure 1.1.2 A Collaborate on and use the community</p>	<p>Required Documentation 1 The Military Installation Department of Public Health may have evolved the community health assessment partnership's membership since the previous accreditation cycle through a diversity, equity, inclusion lens by, for example, considering engagement of community</p>

<p>health assessment process.</p>	<p>members and people with various lived experiences and expertise; adding new or different members to provide additional perspectives; working to retain or more actively engage members; considering methods to intentionally elevate the voices of those that have been traditionally marginalized; or broadening the partnership to include other agencies, units, partners, organizations, stakeholders, associations, or members of the public served by the Military Installation Department of Public Health. Evolution of the community health assessment partnership’s membership may be based on health disparity or health equity data findings.</p> <p>Required Documentation 2 The intent is that the example describes how the community health assessment has provided a foundation for efforts to improve the health of the population. In addition to the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could also provide an example of how the community health assessment or process sparked new ideas or informed the basis for setting priorities, planning, program development, funding application, policy changes or coordination of community resources or collaborative use of assets. The example should be use beyond developing the health improvement plan.</p>
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<p align="center">STANDARD 1.2</p> <p align="center">Collect and share data that provide information on conditions of public health importance and on the health status of the population.</p>	
<p>Foundational Capability Measure</p> <p>Measure 1.2.1 A</p> <p>Collect non-surveillance population health data.</p>	<p>Required Documentation 1: 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 developed and distributed to respondents in the community.</p> <p>If the Military Installation Department of Public Health provides funding for data collection, has a formal agreement for data collection, or works with another entity (e.g., Defense Centers for Public Health (DCPH), an academic institution, DHA, state or local health department, or other organization), community coalitions or collaboratives (e.g., CR2Cs), or an umbrella agency such as the Medical Treatment Facility (MTF), or another division of the umbrella agency (e.g., an MTF’s Population Health Department) 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, the role could be clarified in the Documentation Form.</p> <p>The data collection is intended to enhance the knowledge and understanding of the population served by the Military Installation Department of Public Health. For example, data may pertain to social conditions that have an impact on the health of the population served, such as spousal under- or unemployment issues; lack of accessible facilities for physical activity; housing; transportation; and lack of access to fresh foods.</p> <p>Documentation that may contain primary quantitative (required element a) or qualitative (required element b) data might include, for example, Executive Summaries (EXSUM), Information Papers (IPs), reports or interim progress reports, briefings, minutes of briefings presented, or other communications of the data collected or summary of data and description of why the data were collected.</p>

	<p>For required element a: In addition to the examples provided in <i>The Standards</i> or above guidance, a Military Installation Department of Public Health could also consider primary <u>quantitative</u> data collected 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), surveys to understand the health and wellness needs of special populations such as LGBTQ+ or Single Soldiers, or other closed-ended surveys or quantitative methods designed to gain a deeper understanding of health issues in the community.</p> <p>For required element b: In addition to the examples provided within <i>The Standards</i>, primary <u>qualitative</u> data collection might include results of, for example, focus groups or sensing sessions (e.g., to explore quality of life or factors contributing to higher health risks such as injuries, nutrition, substance use, or behavioral health concerns or other topics), climate assessments, or qualitative data collected as part of the community health assessment process, such as the Mobilizing for Action through Planning and Partnerships (MAPP; National Association of County and City Health Officials (NACCHO)) Forces of Change (FoC) assessment, Community Partners Assessment (CPA) or Community Context Assessment (CCA), etc.</p>
<p>Foundational Capability Measure 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-PH), a Medical Readiness Command (MRC), or a Defense Health Agency (DHA) -market/network, as well as neighboring military, local, or state health department(s). The Installation Department of Health could demonstrate sharing or receiving record-level data through the use of data systems, such as those pertaining to environmental health, worksite air quality, infectious disease reporting, water sample test results (e.g., Defense Occupational and Environmental Health Readiness System (DOEHRS), Disease Reporting System-internet (DRSi)), or other systems.</p>

STANDARD 1.3

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

<p>Foundational Capability Measure Measure 1.3.1 A Analyze data and draw public health conclusions.</p>	<p>Required Documentation 1: For required element a: The data could be collected by the Military Installation Department of Public Health or another entity, as long as it includes data specific to the population served by the Military Installation Department of Public Health. For example, the Military Installation Department of Public Health might consider 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 qualitative data from the Community Themes and Strengths Assessment survey (CTSA) or Community Context Assessment (CCA). Examples include epidemiologic data, vital statistics, workplace injury or disease investigation results, cluster identification or investigation results, outbreak investigation results, environmental and occupational hazard data, population health or community health indicator data, community survey, focus group, or sensing session results and conclusions, outbreak After Action Reports (AARs), analysis of Medical Treatment Facility (MTF) data, analysis of not-for-profit organizations' data (such as poison control center data or child health chart book), health disparities data, environmental health data, occupational health data, socioeconomic data, and stratified health disparities data. Other examples include results of an investigation of a foodborne disease</p>
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	<p>outbreak, noise hazards in the workplace, or trends of reported infectious diseases over the past 5 years. The data may point out 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 options.</p> <p>Program evaluation, customer satisfaction surveys, or employee satisfaction surveys do not meet the intent of this requirement.</p> <p>For required element b: 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-PH), advocacy and service agencies (e.g., Family Advocacy Program (FAP), Army Family Action Plan (AFAP)), the state health department, Armed Forces Wellness Center (AWC), Unit Risk Inventory (URI) survey data, healthcare or dental care data, <i>Health of the Force</i> (HOF) Reports or HOF Online, or other data.</p> <p>For required element c: Other examples of entities that may complete the analysis itself that are applicable to Military Installation Departments of Public health include, but are not limited to, the Defense Centers for Public Health, regional partners (e.g., Medical Readiness Command (MRC), Defense Health Agency (DHA) market/network, state or local health department, or an academic institution, including, but not limited to interns working with the Military Installation Department of Public Health. The analysis of data from multiple data sources (e.g., Armed Forces Wellness Center (AWC) utilization, Unit Risk Inventory (URI), or Medical Treatment Facility (MTF) data, etc.) could be used as sources to demonstrate an understanding of how multiple factors affect health issues.</p> <p>For required element d: In addition to the examples provided in <i>The Standards</i>, conclusions drawn from data analysis might include, for example, identifying implications of social conditions that have an impact on the health of particular or specific populations served, such as spouse under- or unemployment, poor quality housing, lack of transportation, or lack of accessible healthy food options.</p> <p>For required element e: The Military Installation Department of Public Health may engage with a wide range of external stakeholders about findings, for example, community coalitions or collaboratives (e.g., CR2C), healthcare providers or units, veterinarians, installation/garrison or mission/tactical command teams, community service groups, local schools, labor unions, and other public health stakeholders, partners, or groups of the public served by the Military Installation Department of Public Health. Engagement with the governing entity is defined as the commander to whom the Military Installation Department of Public Health's chief ultimately reports that has responsibility for the Military Installation Department of Public Health (usually, the Medical Treatment Facility (MTF) Commander).</p>
<p>Measure 1.3.2 A Use data to recommend and inform public health actions.</p>	<p>Required Documentation 1: In addition to the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate use of the data to inform program improvements or new or revised policies, progress, services, programs, or interventions designed as part of or with community coalitions or collaboratives (e.g., CR2Cs), Public Health Activity, installation/garrison agencies or command, mission/tactical command teams, Medical Treatment Facility (MTF) partners or command, another agency, or developed within the Military Installation Department of Public Health itself to improve the health of the population.</p>

Domain 2

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

STANDARD 2.1

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

Foundational Capability Measure

Measure 2.1.1 A
**Maintain and improve
surveillance systems.**

Required Documentation 1:

For Military Installation Departments of Public Health, surveillance systems might include, for example, the United States Department of Defense's Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), the Defense Occupational and Environmental Health Readiness System (DOEHRS), the Disease Reporting System Internet (DRSi), the Defense Medical Surveillance System (DMSS) or state-notifiable disease reporting systems, or environmental surveillance systems.

For required element a:

The process to maintain the list of surveillance sites might describe, for example, regularly updated and verified lists of sites, such as Medical Treatment Facilities (MTFs), healthcare providers, schools, Child and Youth Services (CYS), laboratories, veterinarians, neighboring local health departments, or state health departments.

For required element c:

For Military Installation Departments of Public Health, the process for using surveillance data could involve analysis performed on behalf of the health department, such as by a partner organization or higher-level agency or organization. For example, the Military Installation Department of Public Health could describe within the narrative, how it assesses surveillance data analyzed by the Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH), a regional partner such as a Medical Readiness Command (MRC), or the Armed Forces Health Surveillance Division (AFHSD) used to identify patterns or trends and to identify differences in population groups or the root causes of disparities. The process for how surveillance system data are used could also describe generating daily, weekly, or other periodic reports, formal or informal, that specifically include data from the jurisdiction served by the Military Installation Department of Public Health. Examples of how surveillance system data were used for item i could include use of the Acute Respiratory Disease Weekly Surveillance Summary, Weekly Influenza Activity Report, or daily reports of patterns of disease incidence. For item ii, the process to use surveillance system data to identify differences in population groups or root causes of disparities could describe, for example, the use of data analyzed from within the Disease Reporting System Internet (DRSi) for sexually transmitted infections (STIs) or other conditions by age, unit, gender, etc.

For required element d:

Military Installation Departments of Public Health may have little to no influence to modify or enhance surveillance systems, however, the narrative could address how requests were made for updates, how staff improved processes to use surveillance systems, such as expanding use of systems, changes to use surveillance system data more rapidly or accurately, or enhancements to ensure surveillance system fields collect appropriate information (e.g., demographic data). The narrative could also address enhancements to staff training to ensure all data fields are accurately entered or methods to standardize data collection, analysis, or use. Since the surveillance systems for Military Installation Departments of Public Health are typically maintained by other agencies and enhancements to the system are not within the department's control, examples to include in the narrative could include, how the

	<p>Military Installation Department of Public Health responds to periodic surveys conducted by the surveillance system manager(s) seeking feedback on potential improvements, feedback submitted via email to the system manager(s), or how the health department has made changes to how it interacts with the surveillance system(s).</p>
<p>Foundational Capability Measure</p> <p>Measure 2.1.2 A Ensure 24/7 access to resources for rapid detection, investigation, containment, and mitigation of health problems and environmental public health hazards.</p> <p>Required Documentation 1. Additional required element d. For Military Installation Departments of Public Health, the policy(ies) or procedure(s) must also address occupational health hazards.</p>	<p>Required Documentation 1: For required element a: Laboratory capacity may be within the Military Installation Department of Public Health, within the Medical Treatment Facility (MTF), regional entities or partner agencies in the military (e.g., Defense Centers for Public Health–Aberdeen (DCPH-A)), the Federal Government, or by private, contracted laboratories, reference laboratories, or a combination of both internal and external support.</p> <p>For required element b: In addition to the guidance in <i>The Standards</i>, the policy or procedure could, for example, address how a Military Installation Department of Public Health accesses epidemiology resources from regional military assets or Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH). This may be documented via a service-specific regulation, Medical Treatment Facility (MTF), Defense Health Agency (DHA), or similar instruction or standard operating procedure.</p> <p>For required element c: 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-PH).</p> <p>For required element d: 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>Measure 2.1.3 A Improve and collaboratively implement practices for investigation, containment, and mitigation of health problems and environmental hazards.</p> <p>Required Documentation 1–3: The Military</p>	<p>For Required Documentation 1–3, the Military Installation Department of Public Health could also use an example of an occupational health hazard, in addition to examples of health problems, or environmental hazards.</p> <p>Required Documentation 1: In addition to the examples provided within <i>The Standards</i>, Military Installation Departments of Public Health could incorporate updates to its practices for investigation or containment or mitigation on what was learned from investigations, events or exercises or the analysis of surveillance data such as the Acute Respiratory Disease Weekly Surveillance Summary, Weekly Influenza Activity Report, or daily reports of patterns of disease surveillance, or based on directives from a higher level and used by the health department to update its practices for investigation, containment, or mitigation based on surveillance data.</p> <p>Required Documentation 2: The intent of this requirement is to work collaboratively on an investigation or mitigation, not to have another entity such as a regional military entity, Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH), or civilian local or state health department carry out the investigation on the health department’s behalf.</p>

**Installation
Department of Public
has the option of
providing examples of
occupational health
hazards.**

The Military Installation Department of Public Health might consider coordinating investigation, mitigation, or containment of health problems, occupational health hazards, or other environmental hazards with civilian state or local health departments where military, local and/or state jurisdictions overlap or are adjacent. The examples could also reflect how the Military Installation Department of Public Health worked in partnership with other military agencies at the installation-level, such as Child and Youth Services (CYS), other installation management assets (e.g., Installation Management Command assets, such as garrison/installation agencies), unit-specific preventive medicine or force health protection officers, military regional or other commands, Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH), or other state or local government departments to demonstrate the capacity to conduct collaborative investigation or mitigation action. Documentation could include, for example, a completed After Action Report (AAR), Executive Summary (EXSUM), Memorandum for Record (MFR), Organizational Inspection Program (OIP) report, Staff Assistance Visit (SAV) report, or narratives of examples.

If there has not been an event within the timeframe, one or more reports of drills or exercises may be provided to meet the number of examples required (i.e., two examples; narratives of examples are acceptable). The Military Installation Department of Public Health is not required to be the lead agency but must have participated in the drill(s) or exercise(s). For Military Installation Departments of Public Health that have not had an investigation within the timeframe, drills performed by Medical Treatment Facility (MTF), garrison/installation commands, other installation or mission/tactical entities, other military public health entities or military Commands or Agencies, as well as civilian agencies such as state or local health departments, can be used for documentation if the Military Installation Department of Public Health can describe how it participated in the drills.

Required Documentation 3:

The Military Installation Department of Public Health could provide an example of an effort or strategy designed to assist, for example, an on-post neighborhood (e.g., a community that experienced high lead levels due to old pipes, or significant mold growth, or asbestos exposure, due to old housing or lack of or poor maintenance), or a subpopulation (e.g., service members living in barracks that are particularly susceptible to an outbreak).

The Military Installation Department of Public Health may or may not be the lead agency and could select a containment or mitigation effort developed in collaboration with others, for example, installation agencies such as the Department of Public Works, or the garrison/installation command, Medical Treatment Facility (MTF) departments, the MTF or installation emergency management office, higher-level commands or agencies, state or local health departments, or other military installation departments of public health and on-post housing offices.

Strategies could address, for example, aspects of the built environment (e.g., water quality, air or water pollutants, soil contamination like brownfields, lead) or climate change; food deserts that affect the population served by the Military Installation Department of Public Health; low rates of certain vaccinations; contact tracing or sexually transmitted infection (STI) partner notification involving undocumented individuals; access to safe conditions in the home, workplace, and congregate living environments (including the barracks) during outbreaks; isolation or quarantine for individuals who are geographically or socially-isolated; ensuring people have access to groceries or essential supplies during isolation or quarantine; or addressing transportation barriers, for example, to access food banks, to access follow-up treatment, or to receive emergency biologics or prophylaxis, especially for one-car households or those with restrictions for ride-sharing or delivery services on-post.

STANDARD 2.2

Prepare for and respond to emergencies.

Foundational Capability Measure

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

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

Required Documentation 1:

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

Required element b:

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

Required element c:

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

Required element e:

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

Required element f:

The process to declare a public health emergency could include, for example, what authorities are needed, or the steps needed to officially make an emergency declaration, and specify the role of the health department in this process. This could include the steps

	<p>(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 2.2.3 A Maintain and expedite access to personnel and infrastructure for surge capacity.</p>	<p>Required Documentation 2: For required element a: For Military Installation Departments of Public Health, the process(es) for expedited administrative procedures could describe how the department receives emergency funds that are made available directly from a military service department (e.g., the Army) or the Defense Health Agency (DHA), for example.</p> <p>For required elements b: The process or set of process(es) for managing or hiring the workforce may be those of the Military Installation Department of Public Health or Medical Treatment Facility (MTF) and may be contained in the Emergency Operations Plan (EOP). This could include, for example, leveraging the MTF's nursing pool, obtaining personnel assigned on a detail from a higher headquarters or other military agency, or training additional health department staff on how to conduct contact tracing.</p> <p>For required element c: The process or set of process(es) for contracting or procuring mutual aid (required element c) may be those of the Military Installation Department of Public Health or Medical Treatment Facility (MTF) and may be contained in the Emergency Operations Plan (EOP).</p>
<p>Measure 2.2.4 A Ensure training for personnel engaged in response.</p> <p>Required Documentation 1. The Military Installation Department of Public Health (DPH) must provide the schedule</p>	<p>Required Documentation 1: The intent of this requirement for Military Installation Departments of Public Health is not to require training on incident command among all staff who may assist in a surge situation. Rather, the intent is to ensure department staff are provided with the training necessary to perform their emergency response roles and responsibilities (which may vary based on position, role, or rank/grade, etc.). Often, the Military Installation Department of Public Health may not have any personnel assigned to perform in an incident command structure (ICS), as functions may be performed outside of the Military Installation Department of Public Health (e.g., by the emergency manager, emergency management coordinator, or Public Health Emergency Officer (PHEO) or Assistant PHEO (APHEO)).</p> <p>The Military Installation Department of Public Health will base its schedule for training or exercises on the role personnel would serve in an emergency situation. The schedule for training or exercises is based regulation, policy, or another authority, such as an Army Regulation (AR). At the time of this publication, the schedule for training or exercises is contained in AR 525–27 and Department of</p>

<p>for training or exercises to prepare Military Installation Department of Public Health personnel who will serve in an emergency response capacity.</p> <p>Incident command or basic FEMA IS 100, 700 and 800 training is required <u>only</u> for those health department personnel, <u>if any</u>, who are performing ICS roles in the installation emergency operations center (EOC) and is not required of all DPH personnel. Other relevant training that is appropriate for those health department staff with emergency response role(s) outside of the installation EOCs ICS may be also provided and should be included in the schedule.</p>	<p>the Army Pamphlet (DA PAM) 525–27. The schedules for training or exercises are generally contained within the Public Health Emergency Operations Plan (EOP), a separate multi-year training and exercise plan, or standard operating procedures (SOPs)/protocols or regulations.</p> <p>Required Documentation 2: Proactive or just-in-time training could include, for example, training on contact tracing, mass vaccination, cleaning and disinfection protocols, or use of specialized insect traps. The trainings used to demonstrate this requirement may be provided by another entity, such as the Medical Treatment Facility (MTF), garrison/installation, service-specific department, Defense Centers for Public Health (DCPH), Defense Health Agency (DHA), or their contractors.</p>
<p>Foundational Capability Measure</p> <p>Measure 2.2.5 A</p> <p>Maintain a risk communication plan and a process for urgent 24/7 communications with response partners.</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), 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>

by another accrediting body against their standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.

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), and/or in conjunction with the relevant public affairs office (PAO) (e.g., the PAO at the Medical treatment Facility (MTF), installation, etc.).

For required element b:

In addition to the examples provided in *The Standards*, 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 (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).

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-PH)/Defense Centers for Public Health (DCPH)), Centers for Disease Control and Prevention (CDC), or state or local health departments.

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.

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.

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.

Required Documentation 2:

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

	<p>Public Health. The process, protocol, or systems for sending 24/7 messages does not need to be the same process, protocol, or system for receiving 24/7 messages. For example, receipt of 24/7 messages may be via the state-wide HAN and/or a 24/7 call-line, while sending 24/7 alerts may be via a phone tree or email message.</p> <p>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>Measure 2.2.6 A Assess potential hazards, vulnerabilities, and resources in the jurisdiction.</p>	<p>Required Documentation 1: Military Installation Departments of Public Health could consider, for example, results of the installation all-hazard assessment, as conducted by the installation’s Directorate of Plans, Training, Mobilization and Security (DPTMS).</p> <p>Note: Full versions of the risk assessment CANNOT be uploaded electronically in a non-governmental information technology system but may be shown in person during the site visit if a Military Installation Department of Public Health plans to use it as documentation.</p>
<p>Foundational Capability Measure Measure 2.2.7 A Conduct exercises and use After Action Reports (AARs) to improve preparedness and response.</p>	<p>Required Documentation 1: 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>Required Documentation 2: 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 listing 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</p>

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

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

<p>Foundational Capability Measure</p> <p>Measure 3.1.1 A</p> <p>Maintain procedures to provide ongoing, non-emergency communication outside the health department.</p>	<p>Required Documentation 1:</p> <p>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.</p> <p>For required element a:</p> <p>In addition to the examples provided in <i>The Standards</i>, 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.</p> <p>For required element b:</p> <p>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 recent Permanent Changes 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.</p> <p>For required element c:</p> <p>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</p>
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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:

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).

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.

*Note: Documentation for this requirement may be similar in intent or the same as 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.

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.

Required Documentation 3:

The Military Installation Department of Public Health's relationship with the media might include communication with members of the media, which include print media, radio, and television; bloggers, web reporters, and diverse media outlets (e.g., installation bulletins or similar media publications, radio stations, community newspapers, ethnically targeted and non-English language newspapers or radio stations, etc.); and involve the relevant public affairs office (PAO) (e.g. installation, Medical Treatment Facility (MTF), and/or regional command).

For required element a:

The Military Installation Department of Public Health might describe, for example, working to proactively build relationships with specific media outlets by working in conjunction with the public affairs office (PAO) (e.g., through meetings or correspondence) or coordinating with the Medical Treatment Facility (MTF) or installation PAO.

	<p>For required element b: The Military Installation Department of Public Health might, for example, describe addressing media stories that include incomplete information or misinformation by disseminating fact sheets, informational briefs, or processes performed in conjunction or by coordinating with the Medical Treatment Facility (MTF) or installation PAO.</p>
<p>Measure 3.1.2 A Inform the public about public health’s role and functions and build a positive reputation of the health department in the community.</p>	<p>Required Documentation 1: Branding strategies that may be used are those specifically developed by or in use at the Medical Treatment Facility (MTF), a higher headquarters agency or command, if permitted for use by the Military Installation Department of Public Health. The branding strategy may be based upon branding already in use at a higher level but should be specific to the Military Installation Department of Public Health.</p> <p>Required Documentation 2: In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health could demonstrate implementation of the department-wide branding strategy (for required elements a-c) through materials that convey the presence of the health department and value of public health through the Military Installation Department of Public Health’s website or the website of a higher-level command or agency. For example, the Military Installation Department of Public Health could use screenshots of a web-posting conveying the presence of the installation and value of public health as a page within the Medical Treatment Facility (MTF) or installation website. The Military Installation Department of Public Health could also demonstrate conveying information about the installation, public health’s value, and its brand and logo, inserted as a section or part of communication or information materials (e.g., presentation, report, or brochure, or social media pages, etc.) maintained by the Armed Forces Wellness Center (AWC), installation, or MTF.</p>
<p>Measure 3.1.3 A Use a variety of methods to make information available to the public and assess communication strategies.</p> <p>Required Documentation 1. Elements f (links to permits and license applications) and i (name of the health department director) are <u>not</u> required for Military Installation Departments of Public Health.</p>	<p>Required Documentation 1: For required element e: Public health-related laws or codes can include military service-specific regulations (e.g., Army Regulation (AR) 40–5, Department of the Army Pamphlet (DA PAM) 40–11), Department of Defense (DoD), Defense Health Agency (DHA) or other military-specific regulations, directives, instructions, and/or codes (e.g., Tri-Service Food Code).</p> <p>For required element f: Links to permits and license applications are not required for Military Installation Departments of Public Health.</p> <p>For required element h: Links could include, for example, state or local health departments, or other Military Installation Departments of Public Health in the region; the Defense Centers for Public Health (DCPH), Defense Health Agency (DHA) market/network, or DHA; or others.</p> <p>For required element i: The name of the health department director is not required for Military Installation Departments of Public Health.</p> <p>For required element k: Comments may be collected through an email address or Interactive Customer Evaluation (ICE), for example. If comments are provided through the Medical Treatment Facility (MTF) website, such as through a contact link or page, the Military Installation</p>

	<p>Department of Public Health may use the Documentation Form to describe how comments applicable to the health department are routed by the MTF to the Military Installation Department of Public Health.</p> <p>Required Documentation 2: The Military Installation Department of Public Health might work in conjunction with the Medical Treatment Facility (MTF) or other applicable public affairs office to describe how assessment finding(s) led to the new or enhanced web or social media strategy. The websites or social media sites may be those of other organizations but are in use by the Military Installation Department of Public Health, to include, but not limited to, the Armed Forces Wellness Center (AWC), installation, or MTF.</p>
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STANDARD 3.2
Use health communication strategies to support prevention, health, and well-being.

<p>Measure 3.2.1 A Design and assess communication strategies to encourage actions to promote health.</p>	<p>Required Documentation 1: This requirement focuses on the approach used at the installation level related to communication strategies the Military Installation Department of Public Health will implement on its own, as well as the approach the Military Installation Department of Public Health uses to implement health-related communication strategies directed from a higher level or chain of command.</p> <p>The department-wide approach for developing and implementing communication strategies may be developed in conjunction with higher chains of command or agencies (e.g., Defense Health Agency (DHA), a military service department or command (e.g., U.S. Army Forces Command), a public affairs office, Medical Treatment Facility (MTF); or other partners (e.g., Commander’s Ready and Resilient Council (CR2C) members); as long as it pertains to the approach used by the Military Installation Department of Public Health.</p> <p>When communication strategies are communicated to the Military Installation Department of Public Health (e.g., through a directive to push out a tobacco prevention campaign from the DHA, military service medical department, or military service department) that gives the Military Installation Department of Public Health discretion to modify or tailor communication strategies, the general approach used by the health department to tailor those communications will be included.</p> <p>For required element a: While some communications may be pre-determined at a higher level or chain of command, such as Defense Health Agency (DHA), where there is discretion on priorities, the Military Installation Department of Public Health’s approach might consider methods to determine an issue is a priority, for example, based on data from the updated <i>Health of the Force</i> Online or other local data to identify priority populations or pressing needs for programming or services, as well as alignment with local or community-based priorities, Department of Defense (DoD), Defense Health Agency (DHA), or military service-specific priority(ies) or directive(s), etc.</p> <p>For required element b: The intent is to describe the approach used to ensure communication strategies are rooted in evidence or science or have been tested. This determination could be based on, for example, internal planning meetings to validate the evidence-base. Examples of sources of evidence-based or promising practices for health communication strategies, may include the Centers for Disease Control and Prevention’s (CDC’s) Clear Communication Index, The Guide to Community Preventive Services, peer-reviewed literature,</p>
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	<p>Defense Health Agency (DHA), Defense Health Agency-Public Health (DHA-PH)/a Defense Center for Public Health, other military or civilian research institutions, or expert opinion when evidence is not available, etc.</p> <p>For required element c: Priority populations could include, for example, active-duty service members; single service members, especially those living in the barracks; pregnant women; junior enlisted service members; and/or LGBTQ+ individuals. Examples of documentation include findings from a focus group, key informant interviews, or pull-aside testing. It could also include minutes from a town hall meeting, planning meeting, community coalitions or collaboratives (e.g., CR2C or CR2C Working Group meetings) with the priority population(s), or a meeting of an advisory group representing the priority population.</p> <p>For required element d: For Military Installation Departments of Public Health, ensuring consistency within procedures for communications may be developed in conjunction with higher level agencies or chains of command, a public affairs office (PAO), Medical Treatment Facility (MTF), or others, as long as the methods to ensure consistency pertain to the communications procedures used by the Military Installation Department of Public Health and specified in Measure 3.1.1, Required Documentation 1.</p> <p>For required element e: Describe the intentional approach to communication, which could include Interactive Customer Evaluation (ICE) feedback, engagement on social media, for example.</p>
<p>Foundational Capability Measure</p> <p>Measure 3.2.2 A</p> <p>Implement and evaluate health communication efforts to encourage actions to promote health and well-being.</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 for one of the examples within the Documentation Form if not evident directly within the documentation. Otherwise, the examples could demonstrate evidence of a chronic disease focused strategy, for example:</p> <ul style="list-style-type: none"> • If the communication strategy is focused on tobacco use prevention, then the strategy itself must specify that not using tobacco or reducing tobacco use are for the purpose of preventing cancer, • 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 human immunodeficiency virus (HIV) transmission, or • If the communication strategy is focused on increasing physical activity or increasing healthy eating, then it also should specifically reference it is for the purpose of heart disease, diabetes, or cancer prevention. <p>For required element a: In addition to the examples provided within the guidance, a Military Installation Department of Public Health might also consider methods to incorporate community voice through message testing, formative evaluation via focus groups, sensing sessions, and/or key informant (or other) interviews, etc. Acceptable efforts to incorporate community voice or public health research include these activities being completed by an external agency or higher Command, such as the Defense Centers for Public Health (DCPH) or Medical Treatment Facility (MTF), for example.</p> <p>For required element b: Examples of potential actions that members of the public should take and why, could include stopping or reducing tobacco use, increasing the intake of fruits and vegetables, obtaining preventive health services like cancer screening, decreasing alcohol consumption, intervening in high-risk situations where they are a bystander, using condoms, seeking prenatal care early, or</p>

	<p>obtaining sexually transmitted infection (STI) testing.</p> <p>For required element c: Beyond what is listed in <i>The Standards</i>, additional examples of demonstrating that the Military Installation Department of Public Health strived for cultural humility and linguistic appropriateness in communications campaigns include the application of learnings from Diversity, Equity, Inclusion, and Accessibility (DEIA) or related trainings. Further, linguistic appropriateness could be demonstrated by using military-specific terminology and graphics, especially for communications aimed at service members.</p> <p>Required Documentation 2: The evaluation need not be formal or comprehensive and could include methods of feedback such as reviewing web or social media analytics or feedback collected from the priority audiences (e.g., feedback about a public service announcement (PSA)). The Military Installation Department of Public Health could also provide a formal or comprehensive evaluation if conducted by the department or others (e.g., local college or university students; Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH); or others).</p>
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<p>Domain 4</p> <p>Strengthen, support, and mobilize communities and partnerships to improve health.</p> <p>For Military Installation Departments of Public Health, the community referred to in this domain includes the population served by the Military Installation Department of Public Health which, at a minimum, includes 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 military units assigned to the installation.</p>	
<p>STANDARD 4.1</p> <p>Engage with the public health system and the community in promoting health through collaborative processes.</p>	
<p>Measure 4.1.1 A Foster cross-sector collaboration to advance equity.</p>	<p>Required Documentation 1: For Military Installation Departments of Health, the approach could address how they partner with entities from sectors other than public health. This could include how they approach their participation within community coalitions, collaboratives, committees, or working groups that involve a broad group of installation, medical/health, and mission/tactical partners (e.g., Commander's Ready and Resilient Councils (CR2Cs) or CR2C Working Group members); installation agencies such as the Directorate of Public Works Housing (DPW), Directorate of Emergency Services (DES), Army Community Service (ACS); or other command/installation services or programs that address social determinants of health, including financial readiness (Financial Readiness Program (FRP) and recreation and morale activities such as Better Opportunities for Single Soldiers (BOSS) and Morale, Welfare, and Recreation (MWR). This documentation could also include how the Military Installation Departments of Health foster collaboration when participating in coalitions, working groups, or committees with off-post partners or a mix of on and off-post partners, which could include off-post community organizations; social service providers/helping agencies; local government, such as county or city health departments; not-for profit organizations; local businesses; health care providers; or others.</p> <p>For required element a:</p>

	<p>In addition to examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could describe fostering a culture of trust across various new or existing collaborations (e.g., working groups, coalitions, councils, or committees), whether the Military Installation Department of Public Health has convened them or actively participated.</p>
<p>Foundational Capability Measure Measure 4.1.2 A Participate actively in community health coalition to promote health equity.</p>	<p>Required Documentation 1: The intent of this measure is to be part of a coalition that is promoting either equity or health equity. Advancing equity does not need to be the primary focus of the coalition, but the coalition will have at least one priority that relates to advancing equity. For Military Installation Departments of Public Health, this should include current, active partnerships (not partnerships that have completed their tasks and disbanded) of which the Military Installation Department of Public Health is an active member. The coalition could be convened by the Military Installation Department of Public Health, the Installation Senior Commander, another command or organization, agencies in neighboring civilian communities, or community members served by the department, etc. The Military Installation Department of Public Health might consider cross-sector coalition(s) already established (e.g., CR2C or CR2C Working Groups) or newly established coalitions based on, for example, issues identified by the community health assessment (CHA), strategies or actions included in the community health improvement plan (CHIP), or issues identified by a sub-group of the CHA or CHIP partnership.</p> <p>For required element b: The participant list must include active members, such as those representing the health sector, non-health sector, and community members which might include, for example, Army Community Service (ACS); Morale, Welfare, and Recreation (MWR); units; family members; the Medical Treatment Facility (MTF); or others. Individuals or organizations that represent populations who have lived experiences with or are disproportionately affected by conditions that contribute to poorer health outcomes could include, for example, individuals who represent junior enlisted (those aged 18–24 within lower enlisted ranks) service members; Better Opportunities for Single Soldiers (BOSS); those served by the Exceptional Family Member Program (EFMP); individuals who identify as LGBTQ+; communities of color; individuals with visual or hearing impairments; or individuals with disabilities. Organizations that represent populations or have expertise addressing inequities could include, for example, civic groups who are specifically tasked with representing those with lived experience or representing specific issues or subpopulations.</p> <p>For required element d: While ultimately the relevant commander (e.g., Senior Commander, Garrison Commander) has final authority to make decisions, the Military Installation Department of Public Health could describe transparent processes allowing for input on certain parts or aspects of the decision-making process or some parts of decisions (e.g., project timelines, steps to develop project milestones, etc.). For example, community coalitions or collaboratives (e.g., CR2C leadership), working groups, or others may make decisions that contribute to decisions ultimately made by a commander.</p> <p>For required element f: For Military Installation Department of Public Health, efforts to explore sustainability of the coalition do not need to focus on financial sustainability and could explore sustainability through social capital, civic engagement, etc.</p>
<p>Measure 4.1.3 A Engage with community members to address public</p>	<p>Required Documentation 1: For Military Installation Departments of Public Health, efforts to promote active participation or eliminate barriers based on a model or framework could consider the installation community as a whole, or a specific group that will be most affected by a policy or strategy. The intent of this requirement is to engage individual community members, not an organization representing population groups. Strategies may be led by the health department, or the health department might participate in these strategies with others,</p>

<p>health issues and promote health.</p>	<p>such as coalitions or collaboratives of which it is a part (e.g., CR2C or CR2C Working Groups, an off-post coalition, Army Family Action Plan (AFAP), etc.). The Military Installation Department of Public Health might consider a strategy implemented to encourage active participation or eliminate barriers among members of the population served by the Military Installation Department of Public Health or a particular group of people within the population served by the health department (e.g., adolescents, single service members, service members who are single parents, Department of Defense (DoD) Civilians, or Retirees). Encouraging active participation could include strategies that promote open dialogue or create spaces where participants feel comfortable speaking candidly, including, but not limited to listening or sensing sessions, focus groups, town hall meetings, or other methods of dialogue. Eliminating barriers could include strategies that reduce stigma around sensitive public health topics, providing childcare or transportation, or other incentives (e.g., a 59-minute early release to Civilian and military personnel). Military Installation Departments of Public Health may use community engagement models, such as Mobilizing for Action through Planning and Partnerships (MAPP), or Community-Based Participatory Research (CBPR), or another model or framework.</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>Foundational Capability Measure</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, 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 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 (DCPH), 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</p>
<p>Measure 5.1.1 A Examine and contribute to improving policies and laws.</p>	

	<p>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:</p> <p>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., 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 Community Health Improvement Plan (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>Foundational Capability Measure</p>	<p>Required Documentation 1:</p> <p>For required element c:</p>
<p>Measure 5.2.1 A</p> <p>Adopt a community health improvement plan.</p>	<p>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.</p> <p>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> <p>For required element d:</p> <p>Community assets and resources could be any resource at the installation or in the broader community that could be used to improve the health of the community. Community assets and resources could include skills and attributes of military personnel and their families, participation of retirees, local on- and off-post organizations, educational opportunities, Morale, Welfare, and Recreation (MWR), institutions (e.g., faith-based organizations such as the chapel; local foundations; institutions of higher learning such as community colleges, universities, etc.), as well as other community factors such as parks, social capital and community cohesion, community resilience, community readiness, a supportive community, etc.</p> <p>For required element e:</p> <p>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>Foundational Capability Measure</p> <p>Measure 5.2.3 A</p> <p>Address factors that contribute to specific populations' higher health risks and poorer health outcomes.</p>	<p>Required Documentation 1:</p> <p>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, 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 which could include, for example, unit leaders, commanders, civic groups who are specifically tasked with representing those with lived experience or representing specific issues or subpopulations.</p> <p>Required Documentation 2:</p> <p>For Military Installation Departments of Public Health, the example or narrative of an example could describe how the department, or its umbrella organization (e.g., the Medical Treatment Facility (MTF) (or another division of the umbrella organization) is implementing Executive Orders (such as Executive Order 14057) or DoD or military service-specific policy about climate change (e.g., DoD Climate Adaptation Plan), such as through the use of energy-efficient government vehicles, recycling initiatives, limiting vehicle emissions, efforts to build community gardens or bring farmer's markets on-post, or MTF sustainability initiatives reported in annual Practice Greenhealth data calls.</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 benefits 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.

<p>Measure 6.1.1 A Monitor and improve inspection activities.</p>	<p>Required Documentation 1: The intent of this requirement is to show that the Military Installation Department of Public Health has a process to review inspection activities (including inspections conducted as a result of complaints as well as inspections conducted on a routine basis) to ensure they are carried out according to protocols. Inspection authority may be located in a regulation, rule, order, standard operating procedure (SOP), pamphlet, or formal agreement (e.g., Memorandum of Understanding (MOU), Memorandum of Agreement (MOA), letter of agreement, or contract).</p> <p>If the Military Installation Department of Public Health is not mandated to perform inspections, required element a must describe the process used by the health department to communicate complaints to entities that have inspection or enforcement authority. In this case, no additional documentation is needed for required element b.</p> <p>For required element a: The Military Installation Department of Public Health will provide both a description of the method for the review and the findings from the review for at least one inspection area or program. The Military Installation Department of Public Health can choose which inspection area or program it will report on or for which it will provide a narrative description to demonstrate conformance with this requirement. The inspection area or program must pertain to those for which the Military Installation Department of Public Health has authority to conduct an inspection of the regulated entity.</p> <p>The Military Installation Department of Public Health must show how inspections or investigation reports are reviewed to demonstrate the health department's adherence to applicable protocols or SOPs. For example, this review may be accomplished by completing an audit of a random sample of inspection or investigation reports.</p> <p>For required element b: The Military Installation Department of Public Health should ensure inspections are performed according to a defined frequency according to, for example a protocol or an algorithm for scheduling inspections. For example, rules requiring dining facility inspections or Child and Youth Services (CYS) inspections on a specified schedule, or a schedule for return inspections after a violation, may be submitted. These may be documents provided by another agency, department, or chain of command that has enforcement responsibilities.</p>
<p>Measure 6.1.3 A Identify and implement improvement opportunities to increase compliance.</p>	<p>For the purposes of this measure, mandated inspections (e.g., food service facility inspections, child and youth services and childcare facilities inspections, worksite noise and other exposure sampling, investigating nuisance or pest complaints) are considered an enforcement activity. Military Installation Departments of Public Health typically perform inspections but do not have enforcement authority; therefore, examples for all requirements in this measure must reflect how the health department assessed</p>

Required Documentation 1:
If the Military Installation Department of Public Health only performs inspections, the examples will reflect how the installation assessed inspection programs, changed its procedures, or other actions taken to improve compliance; and communicated with the public on the purpose of public health regulations, as part of enforcement activities.

If the health department operates an inspection program that is currently out of compliance with local, state, Federal law, or military regulations, then one of the examples must be from that program.

If the health department is responsible for only one inspection program, the health department must submit only one example from that

inspection programs in its areas of responsibility (e.g., worksite inspections, dining facility inspections, etc.), changed its procedures or took other actions to improve compliance, and communicated with the public on the purpose of public health regulations.

Required Documentation 1:

Documentation of assessing inspection programs might include, for example, a summary or notes of discussion during staff or team meetings; a summary report, memorandum, or Information Paper (IP); briefing slides; Memorandum for Record (MFR); or other formal or informal evaluations on compliance or process improvements to inspection protocols or procedures.

For required element a:

The assessment summary could describe, for example, the most common types of **inspections** conducted by the health department; whether complaints in the areas that the health department inspects are happening more frequently within certain units, neighborhoods, or organizations; or whether compliance with inspection procedures (e.g., Tri-Service Food Code, local standard operating procedures (SOPs) has increased or decreased across a timeframe. Patterns or trends could be related to the outcome of the inspections; types of violations; complaints received; unit or shop focus; unit, shop, or neighborhood location; or other factors.

A list of inspections or complaints would **not** meet the intent of this required element.

For required elements b and c:

The intent of these required elements is to evaluate the health department's processes (**not** those of the regulated entity), which could be related to the health department's methods to provide education or inspections to help the regulated entity (e.g., unit, shop, food service facility, Child and Youth Services (CYS) facilities) achieve compliance. Evaluation could identify what parts of the Military Installation Department of Public Health's inspection processes work well and which issues arose with these processes. The intent is **not** to show what worked well or was problematic for a single inspection or investigation **but instead** to evaluate the inspection program's activities and processes, based on a review of its patterns or trends.

For required element d:

For Military Installation Departments of Public Health, recommended changes could relate to, for example, updates to inspection procedures, education or training needs for personnel involved in conducting inspections identified, or opportunities to improve consistency in the application of procedures among staff.

Required Documentation 2:

Documentation of changes to investigation or inspection procedures or other actions taken to enhance enforcement-related activities to improve compliance could include changing one or more aspects of an inspection or complaint investigation procedure (e.g., for noise, pest complaints, worksite air quality concerns, etc.); launching an education campaign for regulated entities (e.g., food service workers, child development center personnel), based on a pattern of complaints, violations, or non-compliance issues across entities; providing new or updated training to regulated entities or personnel to improve compliance in a culturally or linguistically appropriate manner; or changing communication methods to educate the public about the purpose of public health regulations to improve reach.

Required Documentation 3:

<p>program and must indicate in the Documentation Form that the health department is only responsible for the one inspection program.</p>	<p>Military Installation Departments of Public Health that do not have regulatory enforcement responsibility still have a responsibility to foster awareness and knowledge of laws that impact the public’s health. For example, the local school system surrounding the installation community or Department of Defense Education Activity (DoDEA) schools may have the responsibility to ensure that all children entering the facilities kindergarten have had age-appropriate vaccinations. In this instance, the health department could provide education to the public served on the purpose or importance of immunization laws.</p>
<p>Measure 6.1.4 A: Ensure investigation or enforcement activities are carried out collaboratively and equitably.</p> <p><u>Required Documentation 2.</u> If the Military Installation Department of Public Health only performs inspections, the example will reflect steps taken to ensure investigation or enforcement activities are equitably applied OR how it has collaborated with an entity with enforcement authority to foster the equitable application of investigation or enforcement activities.</p>	<p>Required Documentation 2: For Military Installation Departments of Public Health, equitable considerations for investigations could include, for example, steps taken to ensure investigations receive equal response time or follow up, regardless of the rank of the requesting individual or their sponsor, or whether the individual is a service member or a civilian; ensuring high-quality language assistance services are available to promote understanding and demonstrate respect during interactions with regulated entities; or working with people who are marginalized or unempowered to request investigations or enforce, for example, lead abatement, nuisance violations, workplace conditions, or safe drinking water.</p> <p>Even though Military Installation Departments of Public Health have no enforcement authority, the health department must provide an example of how it has collaborated with an entity with enforcement authority (i.e., the applicable commander or their designee), to ensure, advance, or maintain the equitable application, as warranted, of investigation or enforcement activities. Examples could include, but are not limited to—</p> <ul style="list-style-type: none"> • A description of successes or unsuccessful implementation, including what was learned about inequitable application of investigation or enforcement activities performed by the installation or the installation’s work with an entity(ies) with enforcement authority to ensure equitable investigation or enforcement activities; • How the health department worked to strengthen relationships to examine enforcement activities that advance or maintain equity; • How the health department formed or participated in a collaboration, taskforce, or red team to ensure enforcement actions or the lack thereof, do not harm, discriminate, or undermine the health of groups who are at higher risk; • The methods used by the health department and/or enforcement authority to ensure enforcement activities are carried out in an equitable way; or • How the health department and/or enforcement authority worked to ensure accountability of those who may be contributing to inequitable enforcement activities.

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

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

STANDARD 7.1

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

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

Required Documentation 1:
If the Military Installation Department of Public Health's role is not clear from the assessment, the Documentation Form must be used to indicate the Military Installation Department of Public Health's role (as a participant or contributor) or how the Military Installation Department of Public Health reviewed or considered the results of the assessment for each required element, as appropriate.

Required Documentation 1:

The Military Installation Department of Public Health does **not** need to have conducted the assessment of access to health care which could be conducted at a higher level, such as at the applicable Medical Treatment Facility (MTF), Defense Health Agency (DHA) market/network-level, or if working with non-military partners, at a city, county, or regional level. **However**, the intent of the requirement is that the Military Installation Department of Public Health plays a role as a participant to develop, or contribute towards the assessment, or that the Military Installation Department of Public Health has reviewed or considered the results of the assessment to understand the needs of the population served, as well as its use in planning. For example, the collaborative assessment could focus on the utilization of health care services, given the access to health care services afforded to the population served by the Military Installation Department of Public Health, even if conducted at a DHA or DHA market/network-level. The Military Installation Department of Public Health could, for example, describe how it contributed towards the assessment, helped interpret the results, or used the results, for example, as part of its efforts to improve utilization or coordination of care.

The collaborative assessment may be part of the community health assessment or a separate assessment. Multiple assessments may be provided to address one or multiple required elements, as appropriate.

For required element a:

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

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

For required element b:

Data on populations who experience barriers or lack of access to care may be obtained, for example, from an assessment survey and/or surveys of particular population groups, a review of measures such as Healthcare Effectiveness Data Information Set (HEDIS) to assess health care service utilization; or meeting minutes or reports determining the need and/or impact of a Patient-

Centered Medical Home (PCMH) or community-based medical homes or different MTFs or services within a Defense Health Agency (DHA market/network). Other information sources include analysis of secondary data and/or health care data, such as emergency department admissions, population insurance status data, or other sources, for example, assessing access to contraceptive care by examining data from the Department of Defense (DoD) Contraceptive Program or Deployed Prescription Program (DPP), or results from the Women's Reproductive Health Survey (WRHS), or other data.

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

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

For required element c:

The Military Installation Department of Public Health's or partnership's review of data on the availability and gaps in services might consider, for example, the availability or utilization of health care services, for example, clinical preventive services, Emergency Medical Services (EMS), emergency departments, urgent care, occupational medicine, ambulatory care (primary and specialty), inpatient care, chronic disease care (e.g., diabetic care, human immunodeficiency virus (HIV) health services), dental, behavioral health, and other health care services. The assessment might include, for example, Medical Treatment Facility (MTF) clinical operations, or of population health or managed care data that identify the availability or utilization of services and gaps in services, HEDIS measures from the MTF or the Defense Health Agency (DHA) market/network, or vaccination rates for Active-Duty Military personnel and/or eligible beneficiaries. Assessment of services could also include, for example, the capacity and geographic distribution of providers (e.g., patient/provider ratios within the MTF or referral markets/networks, or those accepting new clients); or services that are not widely available (e.g., services with long wait times to get appointments, or areas within the jurisdiction with limited or no providers in general or within a specific specialty). Data used in the analysis may include secondary sources, such as TRICARE, DHA, or DHA market/network data.

For required element d:

Conclusions may be drawn, for example, from various partnership sources, such as, the Medical Treatment Facility's (MTF's) clinical operations, or of population health, utilization, or managed care data, Defense Health Agency (DHA) or DHA market/network, or TRICARE data that identify and describe gaps in utilization of, access to, and barriers to health care services, or any of the data used in the assessment as documented for required elements b and c. Conclusions should be based on analysis of data and can help develop effective strategies to ultimately address gaps in health care utilization or access.

For required element e:

	<p>The assessment could consider a variety of emerging issues, such as, changes in the structure of the health care system, the advent and impact of Defense Health Agency (DHA) markets/networks, the capacity of the current and future provider workforce (e.g., ratios or specializations of current or future providers); changes in reimbursement (e.g., structure, rates, or payment mechanisms, including, accountable care organizations); development of other care models (e.g., patient-centered medical homes, coordinated care organizations, or convenient care clinics); as well as the impact of data or information system modernization, such as new or improved electronic health/medical records (EHR/EMRs), such as the transition to MHS Genesis.</p>
<p>Measure 7.1.2 T/L Implement and evaluate strategies to improve access to health care services.</p>	<p>Required Documentation 1: The Military Installation Department of Public Health does not need to have convened or led the collaborative process, but the department’s role will be indicated to show how the department participated in implementing strategies. In addition to the examples provided in <i>The Standards</i>, the collaboration could include working with community coalitions or collaboratives (e.g., CR2Cs), working groups, patient advocacy groups, or others.</p> <p>Examples could also include documentation that indicates the Military Installation Department of Public Health’s role in the following:</p> <ul style="list-style-type: none"> • Documented referral system between two or more Medical Treatment Facility (MTF) departments; the Military Installation Department of Public Health’s services and one or more MTF departments; or with the MTF or Military Installation Department of Public Health and providers in the market/network or off-post community that shows the methods used to link individuals with needed health care services. • Documented referral system between the MTF contraceptive clinic and sexually transmitted infection (STI) clinic. • Coordinated and integrated behavioral, public health, and primary care services. • Documented referral system between women, infants, and children (WIC) (or other identified sub-population) and service providers, such as pediatric clinics. (Note that a referral system to social service providers would not meet the intent of the measure, as collaborating with other sectors to improve access to social services is covered under Measure 7.2.1 A.) • Collaboration with behavioral health and tactical/mission units on a campaign to reduce stigma associated with seeking behavioral health services. • Increase in the availability or methods to access timely care through telehealth services or other mechanisms. • Transportation mechanisms or coordination of services, for example, for individuals who are homebound or in a single-car household. • Arrangements for child care for patients to enhance service utilization. • After-hours or weekend clinics for women’s health or children’s health. <p>Required Documentation 2: For Military Installation Departments of Public Health, evaluation feedback gathered from patient populations who were the focus of the strategy might include, for example, Interactive Customer Evaluation (ICE), Joint Outpatient Experience Survey (JOES), TRICARE Inpatient Satisfaction Survey (TRISS), or other data collected directly from patient population(s) who were the focus of the strategy. The feedback collected from individuals is not required and may be summarized to show the results of the evaluation. The Documentation Form may be used to describe who participated in the evaluation. The evaluation does not need to be complex, formal, or costly and could focus on a variety of topics, for example, costs, timeliness or availability of appointments, increased service utilization, or improved health status or outcomes, etc.</p>

STANDARD 7.2

Connect the population to services that support the whole person.	
Foundational Capability Measure Measure 7.2.1 A Collaborate with other sectors to improve access to social services.	<p>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., CR2Cs) meetings in order to improve access to social services such as—</p> <ul style="list-style-type: none"> • Co-location of social services in a convenient location, for example social service aspects of WIC services by the host installation or at the Medical Treatment Facility (MTF) • Referral systems from primary care or behavioral health to Army Community Service 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 MTF Sexual Harassment/Assault Response and Prevention (SHARP) Program or staff, or Armed Forces Wellness Centers (AWCs) • Integration of behavioral or social service questions into screenings.
Measure 7.2.2 A Collaborate with other sectors to ensure access to care during service disruptions.	<p>Required Documentation 1: Strategies within the military setting may include working with partners on and/or off-post to ensure military beneficiaries obtain care or social services in the event of service disruption. This collaboration could include establishing systems of care with other military Medical Treatment Facilities (MTFs), within a Defense Health Agency (DHA) market/network or across DHA markets/networks; with local, off-post and civilian health care or social service partners; or with on-post service agencies such as the MTF, Army Community Service (ACS); tactical/mission units; or others. It may also involve the American Red Cross, the National Guard, or other agencies that provide assistance during such events.</p> <p>Additional documentation could include, for example, the MTF or installation Emergency Operations Plan (EOP) or a related annex showing the involvement of the department of public health or its personnel, including, but not limited to the Public Health Emergency Officer (PHEO) or Assistant PHEO (APHEO).</p>

Domain 8	
Build and support a diverse and skilled public health workforce.	
STANDARD 8.1	
Encourage the development and recruitment of qualified public health workers.	
Foundational Capability Measure Measure 8.1.1 A Recruit and promote the development of a qualified and diverse public health workforce.	<p>For Military Installation Departments of Public Health, this measure pertains only to the civilian workforce.</p> <p>Required Documentation 1: For required element a: Military Installation Departments of Public Health may describe their use of Federal Office of Personnel Management (OPM), DoD, or a military service department’s recruiting and hiring policies, such as those providing preference to veterans, spouses of active-duty service members, spouses or widows of service members injured or killed in action, family members of active-duty service members stationed overseas, and individuals with disabilities. The description could include, for example, how the Installation provides suggestions to Human Resources (HR) on recruitment or hiring policy or practices; how the department reviews</p>

	<p>qualifications listed in job descriptions using a diversity, equity, and inclusion lens; or how the Military Installation Department of Public Health provided suggestions to HR on dissemination of job openings to recruit a workforce reflective of the diversity within the Military Installation Department of Public Health's community.</p> <p>For required element b: In addition to the examples provided in <i>The Standards</i>, Military Installation Departments of Public Health might also consider collaboration with others in the military or coordination with local universities, colleges, or trade schools as part of recruitment booths or events. Collaboration could also leverage relationships with the community surrounding the installation or with other organizations, such as those convened to support veterans with lived experience (e.g., spouses' clubs, family readiness groups, among others). Collaborative relationships may also be with on- or off-post organizations and may involve formal or informal relationships to recruit for Military Installation Department of Public Health positions.</p> <p>For required element c: For Military Installation Departments of Public Health, collaboration to build a pipeline of future public health workers could also address working across the DoD or within a specific military service department, as well as with community organizations or colleges, universities, or trade schools to promote public health as a career choice. Examples include hosting hands-on learning or lectures, or participating in career fairs that focus on public health (e.g., what public health is, what the Military Installation Department of Public Health does, as well as training or positions within the Military Installation Department of Public Health, DHA, DoD or other military service department public health careers, such as epidemiologist, nursing, environmental health, emergency preparedness, health promotion, etc.). Collaborative efforts could be held annually or multiple times throughout the year. Efforts to collaborate could be through solidified processes with established or new partners, or may be new or innovative processes with current or new partnerships to build the pipeline.</p>
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STANDARD 8.2
Build a competent public health workforce and leadership that practice cultural humility.

Foundational Capability Measure	Required Documentation 1:
Measure 8.2.1 A Develop and implement a workforce development plan and strategies.	<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</p>

health preparedness, and informatics competencies.

For required element c:

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

For required element d:

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

For required element e:

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

Required Documentation 2:

Beyond the examples listed in *The Standards*, the impact of implementing the Military Installation Department of Public Health's workforce development plan, could assess whether outcomes are successful or unsuccessful, or could relate to, for example, further transparency or clarity regarding department workforce needs or the effectiveness of strategies to address gaps in department workforce capacity or competency. The impact could also be described as improved employee satisfaction; new or improved processes, public health services or programs, or partnerships; or enhanced ability to convey the needs for public health workforce training to the military medical service departments (e.g., schools/training sites, specialty consultants) or the Defense Health Agency (DHA), for example.

Required Documentation 3:

In addition to the examples provided within *The Standards*, the Military Installation Department of Public Health's description could focus on policies or processes related to utilizing leadership or professional growth training opportunities, such as professional military education (e.g., Captain's Career Course, Intermediate Level Training, etc.), civilian education (e.g., Civilian Education System), or leveraging other professional growth opportunities available at the installation or Medical Treatment Facility (MTF),

	<p>within the Defense Health Agency (DHA), or within a specific military service department to support leadership skills as part of succession planning.</p>
<p>Measure 8.2.2 A Build a supportive work environment.</p> <p>Required Documentation 1: The Military Installation Department of Public Health's policy or set of policies must cover methods to build a supportive work environment for the entire workforce, inclusive of both military and civilian personnel (for required elements a–d).</p>	<p>Required Documentation 1: The intent of this requirement is to provide policies that go above and beyond state and federal laws to build a supportive work environment for staff. Documentation for this measure may require collaboration with the human resources office of the Military Installation Department of Public Health's supporting organization (e.g., the Medical Treatment Facility (MTF)). Supporting documentation may include that from higher level agencies (e.g., Defense Health Agency (DHA); DoD), military commands, or from federal agencies such as the U.S. Office of Personnel Management (OPM).</p> <p>For required element a: Worksite health and wellness programs help employees modify their lifestyles and move toward an optimal state of wellness. They can produce organizational and employee benefits, such as lower healthcare costs, increased productivity, improved recruitment and retention, reduced absenteeism, and enhanced employee engagement. Worksite health and wellness interventions include, but are not limited to, ergonomic support (e.g., standing desks), health education, nutrition services, lactation support, physical activity promotion, health screenings, vaccinations, traditional occupational health and safety, disease management, and linkages to related employee services. Examples include Armed Forces Wellness Centers (AWCs), agency civilian fitness policies, and special wellness events or services offered to military and/or civilian employees.</p> <p>For required element b: For Military Installation Departments of Public Health, work/life balance may also support leave and pass processes affording flexibility in the types of leave, or assignment accommodations for dual-military couples through a Married Couples Program. Work-life balance policies could also address the needs of activity duty single parents balancing caring for their families while meeting service member requirements or work expectations; aspects of a family care plan; pregnancy, pregnancy loss, or postpartum support; telework; alternative work schedules; family, paternity, or maternity leave; breastfeeding/lactation support, etc.</p> <p>For required element c: Examples can address both team and individual recognition and recognition for employee improvement. Examples of employee recognition include an employee-of-the-month program, posting an employee honor roll, a cash or time-off/pass award program (for civilian and military personnel, respectively), recognition certificates or letters, regularly organized recognition ceremonies, and applicable agency or military service department-specific awards, etc.</p> <p>Required Documentation 2: In addition to the examples provided within <i>The Standards</i>, the Military Installation Department of Public Health might also consider staff assessment feedback received through listening or sensing sessions to assess the organizational climate, or via surveys, such as command climate surveys or staff polls. Efforts taken to improve the work environment or employee satisfaction could also include providing input to a broader agency; a higher headquarters (HQ) or umbrella agency, such as the Medical Treatment Facility (MTF), Defense Health Agency (DHA) or another military command or agency related to these organizations' policies or practices to support work-life balance, employee recognition, wellness, or staff inclusion.</p>

Domain 9

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

STANDARD 9.1

Build and foster a culture of quality.

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

Foundational Capability Measure

Measure 9.1.1 A Implement the performance management system.

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.

*Note: Documentation for this requirement may be similar in intent or the same as 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 element a:

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).

Required Documentation 2:

In addition to examples provided in *The Standards*, the Military Installation Department of Public Health might consider customer feedback collected through forms, surveys, focus groups, sensing sessions, or department comment cards (e.g., Interactive Customer Evaluation (ICE) comments). Satisfaction or performance data collected for other purposes may be used if they relate to the Military Installation Department of Public Health's performance management system and can show implementation of such (e.g., as part of a quality improvement project). The example may relate to external customers such as installation tenant organizations, food establishment operators, healthcare beneficiaries enrolled at the Medical Treatment Facility (MTF), etc. If tied to an administrative goal, the customers could also be internal to the Military Installation Department of Public Health (e.g., staff/leadership, etc.).

STANDARD 9.2

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

<p>Foundational Capability Measure</p> <p>Measure 9.2.1 A Base programs and interventions on the best available evidence.</p>	<p>Required Documentation 1: In addition to the examples provided in <i>The Standards</i>, the process used by the Military Installation Department of Public Health might also examine looking for evidence-based or promising practices from military-specific sources, such as the Defense Centers for Public Health (DCPH), Defense Health Agency (DHA), or military service-specific agencies (e.g., U.S. Army Medical Command (MEDCOM), Walter Reed Army Institute of Research (WRAIR), or U.S. Army Institute of Environmental Medicine (USARIEM)) when a program or intervention is developed or revised. The process could also include less formal sources such as a peer Military Installation Department of Public Health; literature reviews; consultants internal or external to the military; academia; researchers; or other experts.</p> <p>Required Documentation 2 Adoption of an evidence-based or promising practice that has been customized to be appropriate for the community and the community’s particular characteristics might be demonstrated, for example, through Memorandums for Record (MFRs), reports, briefings, public program descriptions (e.g., newsletters, program websites), or other program descriptions. 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 (AWC) clientele as part of increasing 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 on-post housing units.</p> <p>Required Documentation 3: For Military Installation Departments of Public Health, the evaluation does not need to be formal but should demonstrate structured collection of data or a systematic or standardized approach. Data used to inform the improvement are not required, but might include, for example, feedback collected during sensing sessions, town halls, focus groups, or surveys. The evaluation could be conducted by the Military Installation Department of Public Health or by other entities, such as local universities (e.g., as part of student projects), partner organizations, or others, such as Defense Centers for Public Health (DCPH)/Defense Health Agency-Public Health (DHA-PH).</p>
<p>Measure 9.2.2 A Foster innovation.</p>	<p>Required Documentation 1: In addition to the examples provided in <i>The Standards</i>, the Military Installation Department of Public Health could also describe, for example, conducting a stand-down or brainstorming session focused on innovation topics.</p>

Domain 10

Build and maintain a strong organizational infrastructure for public health.

STANDARD 10.1
Employ strategic planning skills.

**Foundational
Capability Measure**

Measure 10.1.1 A
**Adopt a department-
wide strategic plan.**

Required Documentation 1:

The Military Installation Department of Public Health's process may have been part of a larger strategic planning process for the organization to which it belongs (e.g., Medical Treatment Facility (MTF), etc.). If such is the case, the Military Installation Department of Public Health must have been actively engaged in the process and must provide evidence that public health was an integral component in the process.

Some Military Installation Departments of Public Health may have shorter planning timeframes and may produce a strategic plan every 2 years, for example. Some of the goals in the plan may be set for a period of longer than 5 years, but the plan must have been produced or revised within the last 5 years.

For required element a:

For Military Installation Departments of Public Health, engagement of staff at all department levels includes leadership, managers, and non-managerial, including frontline and administrative staff. Engagement with representative(s) of the department's governing entity (e.g., Medical Treatment Facility (MTF) commander; see the domain description for full definition of the governing entity) could also include engagement with the advisory board (e.g., the MTF command team).

Required Documentation 2:

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). If such is the case, the plan must include a section that addresses the Military Installation Department of Public Health and includes the required elements of the plan 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., 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.

Measure 10.1.2 A
**Monitor
implementation of the
department-wide
strategic plan.**

Required Documentation 1:

If monitoring of progress towards all strategic plan objectives is performed by an umbrella agency (e.g., Medical Treatment Facility (MTF)), the Military Installation Department of Public Health's participation or contribution to the review process may be indicated in the examples or described in the Documentation Form. Alternatively, if the Military Installation Department of Public Health's strategic plan is contained within the plan of an umbrella agency (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), MTF, etc.), and progress reports are not available or conducted by that agency, the Military Installation Department of Public Health may develop its own progress reports showing strategic plan implementation and the progress reports may focus only on the Military Installation Department of Public Health's specific strategic plan objectives.

Required Documentation 2:

For Military Installation Departments of Public Health, communication with the governing entity regarding implementation of the strategic plan could include, for example, the Medical Treatment Facility (MTF) commander. For a description of the governing entity) or advisory board (e.g., MTF command team), refer to the introduction of ***The Supplemental Guidance*** (this document).

STANDARD 10.2

Manage financial, information management, and human resources effectively.

Foundational Capability Measure

Measure 10.2.1 A Manage operational policies, including those related to equity.

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-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 Division (RMD) or Information Management Division (IMD). 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.

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 U.S. Government Office of Personnel Management (OPM) policies would **not** meet the intent of this requirement.

*Note: Documentation for this requirement may be similar in intent or the same as used for Medical Treatment Facility (MTF) 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 its standards does not ensure that the documentation will be assessed as demonstrating conformity with PHAB requirements.

For required element a:

The Military Installation Department of Public Health's policies and procedures do not need to be created by the department; they may have been 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 *used* by the Military Installation Department of Public Health and include a description of the process, frequency, and method used by the Military Installation Department of Public Health to influence reviews and revisions.

For required element c:

The Military Installation Department of Public Health might consider, for example, how directives or changes from the Office of Personnel Management (OPM), Defense Health Agency (DHA), the Medical Treatment Facility (MTF), or other local operational policies are communicated to staff.

Required Documentation 2:

The Military Installation Department of Public Health may either adopt its own definitions of equity terms or rely on those of a Government-wide, higher headquarters, or umbrella agency (e.g., the Department of Defense (DoD), Defense Health Agency (DHA), Medical Treatment Facility (MTF), etc.). 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>Required Documentation 3: 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>Foundational Capability Measure Measure 10.2.2 A Maintain a secure information management infrastructure to support strategic goals.</p> <p>Required Documentation 1: Military Installation Departments of Public Health can provide either 1 department-wide policy or 2 examples of policies that each address required elements a–c.</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, Medical Protection System (MEDPROS), Defense Occupational and Environmental Health Readiness System (DOEHRS), or Disease Reporting System Internet (DRSi), so long as each address 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, personal identification numbers (PINs), 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: The Military Installation Department of Public Health may have limited ability to implement improvements to its information management systems; however, the example or narrative of an example could instead address how the department has worked with or submitted requests to those responsible for maintaining systems or system upgrades/improvements or considered the alignment of improvements to advance the strategic goals of the Military Installation Department of Public Health.</p> <p>Examples of how the Military Installation Department of Public Health could demonstrate improvements it has made and/or requested could include documentation that shows when and how the department requested updates to its portion of the website, submitted requests to replace outdated technology or hardware/software applications to support a productive workforce, or requested updates or improvements to software applications, for example, enhancements to surveillance systems or systems for tracking and monitoring inspections (e.g., food establishments, workplaces, etc.).</p>
<p>Foundational Capability Measure Measure 10.2.4 A Oversee financial management systems.</p>	<p>Required Documentation 1: This requirement does not apply to Military Installation Departments of Public Health.</p> <p>Required Documentation 2: The Military Installation Department of Public Health may use an improvement made to processes related to written agreements, contracts or grants internally (within the Department of Public Health) or an improvement made in conjunction with the appropriate</p>

<p><u>Required Documentation 1:</u> This requirement does not apply to Military Installation Departments of Public Health. No documentation is required to demonstrate all formal communications from state or federal funders that indicate the health department is a “high-risk grantee.”</p>	<p>department or office within the Medical Treatment Facility (MTF) that manages written agreements, contracts, or funding requirements from Defense Health Agency (DHA) or a DHA market/network, or other organization that provides this support to the department.</p> <p><u>Required Documentation 3:</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 4:</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>
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STANDARD 10.3
Foster accountability and transparency within the organizational infrastructure to support ethical practice, decision-making, and governance.

<p>Measure 10.3.1 A Deliberate and resolve ethical issues.</p>	<p><u>Required Documentation 1:</u> The Military Installation Department of Public Health may maintain its own process to deliberate and resolve ethical issues. Alternatively, the Military Installation Department of Public Health might rely upon a process to deliberate and resolve ethical issues developed or maintained by a broader or umbrella agency, such as the Medical Treatment Facility (MTF), under the direction of the MTF commander or command team, if the process includes required elements a–d. If the process of a broader or another agency is used and only addresses some of the required elements (e.g., required elements a–c, but not d), the Military Installation Department of Public Health could also develop a supplemental or companion document describing the process that would be used for the remaining required element (e.g., addressing required element d). The process may be described in an ethics training or policy or procedure, or description of the functions of an Ethics Committee, for example, or another document describing the process to deliberate and resolve ethical issues that may arise in compliance with appropriate command and control channels and military procedures.</p> <p><u>Required Documentation 2:</u> The Military Installation Department of Public Health will provide evidence of application of the process for ethical issues (from Required Documentation 1). If the process described in Required Documentation 1 is that of a broader or umbrella agency, the Military Installation Department of Public Health will show how that process was applied to the resolution or prevention of the occurrence of an ethical issue within the context of the Military Installation Department of Public Health, such as in the deliberation of a public health, management, or other issue of the Military Installation Department of Public Health. Examples of ethical issues include addressing issues of child vaccination exemptions in Child and Youth Services (CYS), distribution of flu vaccine in a shortage situation, an employee’s use of social media, or an employee’s acceptance of gifts.</p>
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<p>Foundational Capability Measure</p> <p>Measure 10.3.3 A</p> <p>Access and use legal services in planning, implementing, and enforcing public health initiatives.</p>	<p><u>Required Documentation 1:</u></p> <p>The Military Installation Department of Public Health must document that it has access to legal counsel for review and advice, as needed. Legal review within the originating military 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 agency (e.g., Medical Treatment Facility (MTF)), on the installation (i.e., a garrison Judge Advocate Office), or at higher levels (e.g., the Defense Health Agency (DHA)).</p>
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